

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2260

CERTIFICATE OF DEATH

02221

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN X Crownsville		7 yrs. 2 mos. 4 days		TOWN Baltimore City		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital				STREET ADDRESS West Street ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) James (Middle) Alton (Last)				(Month) 3 (Day) 21 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Negro	Unk.	1870 ?	84 ? yrs.	Months —	Days —	Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Unknown		Maryland		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Edward Alton				Mary Elizabeth Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		Unk.		Unk. Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis							
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Cardiovascular Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/21/55 to 3/21/55, that I last saw the deceased alive on 3/21/55, and that death occurred at 11:00 p.m. from the causes and on the date stated above.							
SIGNATURE L. Benedict, M. D.				ADDRESS (Street, city, town, state) Crownsville, Md.		DATE SIGNED 3/22/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF 3/28/55		NAME OF CEMETERY OR CREMATORY Crownsville State Hospital		LOCATION (City, town, or county) Crownsville, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Mar 28 55		H. M. S. J.		Arnold H. Eicher		Crownsville, Md.	

DEATH CERTIFICATE

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Certificate	

BUREAU V. S.

MAR 30 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2261
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 02222/
No. 28

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Caroline	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN Ridgeley	
X TOWN Crownsville		22 yrs. 10 mos.		TOWN		05X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural, give location) None listed			
3. NAME OF DECEASED:		(First) Ethel		(Middle)		(Last) Armstrong	
(Type or Print)							
5. SEX: Female		6. COLOR OR RACE: Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW		8. DATE OF BIRTH: 1905?	
						9. AGE last birthday: 49? yrs.	
						10. DATE OF DEATH: 3 2 19 55	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housework				10b. KIND OF BUSINESS OR INDUSTRY: - - -		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: Fred Smith				12. CITIZEN OF WHAT COUNTRY? U. S.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unk. Unk.				16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Hospital Records	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				3 days			
Immediate cause (a) Acute Cardiac Failure							
DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: 2				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
J. E. Boulais		3/5/55		Union		Goldboro, Md.	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR. ADDRESS	
Burial		3-3-55		J. E. Boulais		Goldboro, Md.	

RECEIVED

MAR 8 1965

BUREAU V. S.

2262

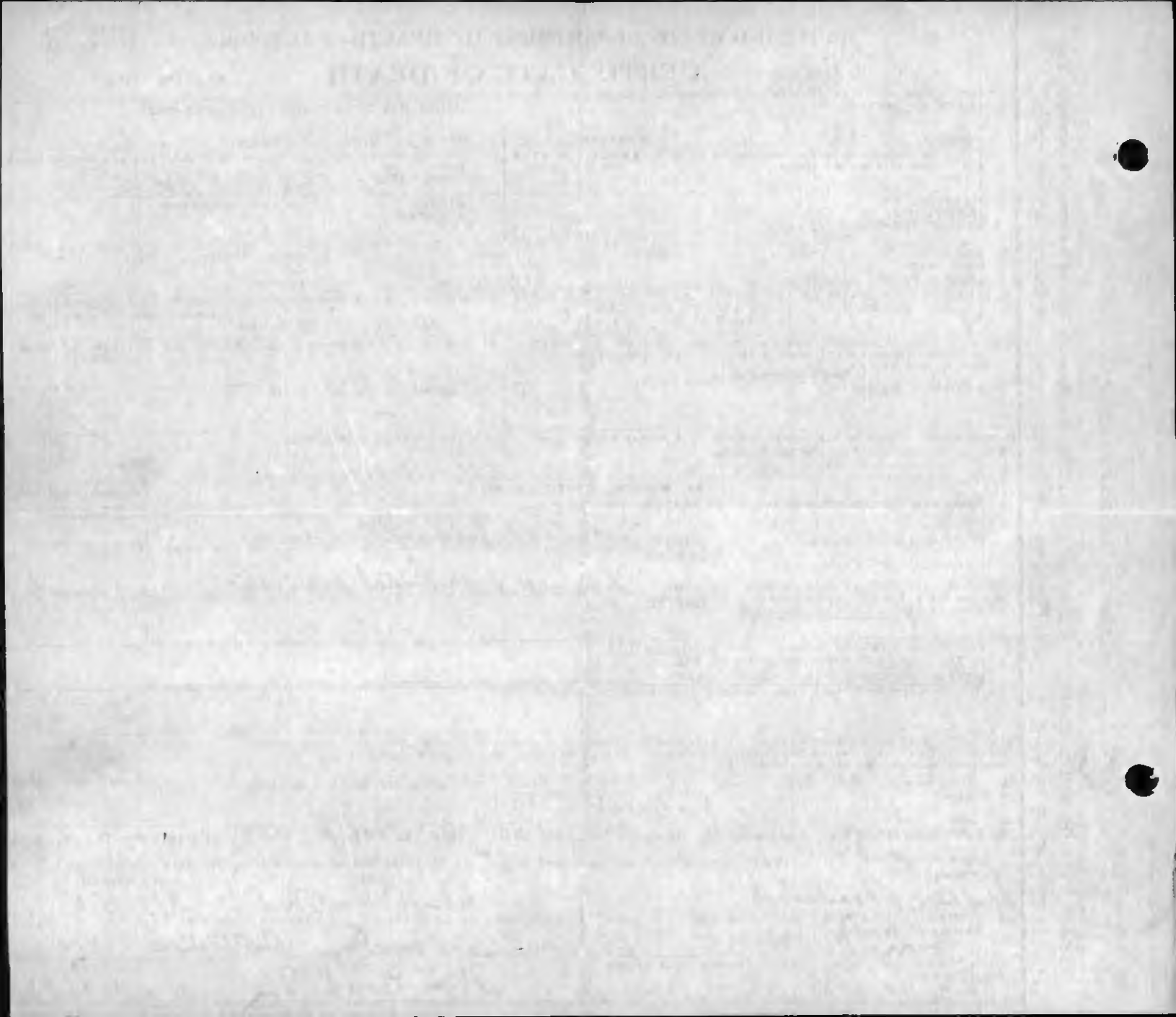
CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>A.A.C.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>A.A.C.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>MILLERSVILLE</u>		<u>3 MO</u>		TOWN <u>BROOKLYN PARK</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 SAHN'S NURSING HOME</u>				STREET ADDRESS (If rural give location) <u>6020 LITCHFIELD HGV</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar 9 1955</u>			
<u>RAYMOND</u> <u>ARNOLD</u>							
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>SEPT. 14, 1878</u>	9. AGE last birthday: <u>76</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unknown</u>				10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>—</u>				14. MOTHER'S MAIDEN NAME: <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Y</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>MRS. E. AUSTIN 6020 LITCHFIELD HGV</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>592X Mitral Insufficiency</u>						+ 3 months	
ANTECEDENT CAUSE (B) <u>Chronic Interstitial Nephritis</u>						+ 3 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 20, 1950</u> , to <u>March 8, 1955</u> ; that I last saw the deceased alive on <u>March 8, 1955</u> , and that death occurred at <u>8:15 A. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James H. Rankin</u>				ADDRESS <u>M.D. Glen Burnie, Md</u>		DATE SIGNED <u>3/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/11/55</u>		<u>St. Paul's Cemetery</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-10-55</u>		<u>G. W. Hedgcock</u>		<u>Wm. Cook Inc.</u>		<u>1212 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2237

02225

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> TOWN <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63</u> <u>ANNE ARUNDEL GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>22 BLOOMSBURY SQUARE</u>			
3. NAME OF DECEASED (Type or Print) <u>RUBY</u> (First) <u>E</u> (Middle) <u>BASSFORD</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH</u> <u>19</u> <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 2, 1901</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-305703</u>		17. INFORMANT & ADDRESS <u>MR GEORGE C. BASSFORD* Husband-same as #2</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
199.9 IMMEDIATE CAUSE (A) <u>Pneumothorax (pleural a?)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinomatosis</u>						<u>7 mon</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0 -</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office-bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>July, 19 54</u> to <u>3/19/19 55</u> , that I last saw the deceased alive on <u>3/19/19 55</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>				M.D. <u>Annapolis, Md</u>		DATE SIGNED <u>3/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 21, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>March 21, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	

100-300000

MAKING STATE OF ARIZONA DE HEALTH - ALBUQUERQUE, N.M.

CERTIFICATE OF DEATH

100-300000

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DEATH CERTIFICATE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DEATH CERTIFICATE

DATE OF DEATH

100-300000

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

100-300000

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

100-300000

PLACE OF DEATH

CAUSE OF DEATH

100-300000

BUREAU V. S.

MAR 27 1955

RECEIVED

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

MAR 27 1955

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2238

CERTIFICATE OF DEATH

02226

Reg. Dist. No. 21

item 7. Film GL79 4-7-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) Annapolis		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Green Haven, PASADENA, Md.		X	
TOWN Annapolis				STREET ADDRESS (If rural give location) Outing Ave. & 2nd St.		1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) John		(Middle) (none)		(Last) Bialozynski		(Month) March (Day) 27, (Year) 19 55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Unknown	9. AGE last birthday 687 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Handyman		10b. KIND OF BUSINESS OR INDUSTRY Home Improvement		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Bialozynski				14. MOTHER'S MAIDEN NAME Josephine Prosinska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Martin Sass Camp Meade Rd.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) Pulmonary Edema				INTERVAL BETWEEN ONSET AND DEATH 4 Hours			
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Arteriosclerotic Heart Disease				UNKNOWN			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/27 , 19 55 , to 3/27 , 19 55 , that I last saw the deceased alive on 3/27 , 19 55 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.							
SIGNATURE Edward A. Beck				M. D. 4 Southgate Ave. Annapolis		DATE SIGNED 3/28/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEROF April 1, 1955		NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
24. REC'D BY REGISTRAR 4/1/55		REGISTRAR'S SIGNATURE Wm. J. French		25. FUNERAL DIRECTOR'S SIGNATURE George Vance		ADDRESS 4001 Ritchie Hwy.	

CERTIFICATE OF DEATH

3538

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

John A. Brown

BUREAU V. S.

APR 1

RECEIVED

2263

MARYLAND STATE DEPARTMENT OF HEALTH

02227

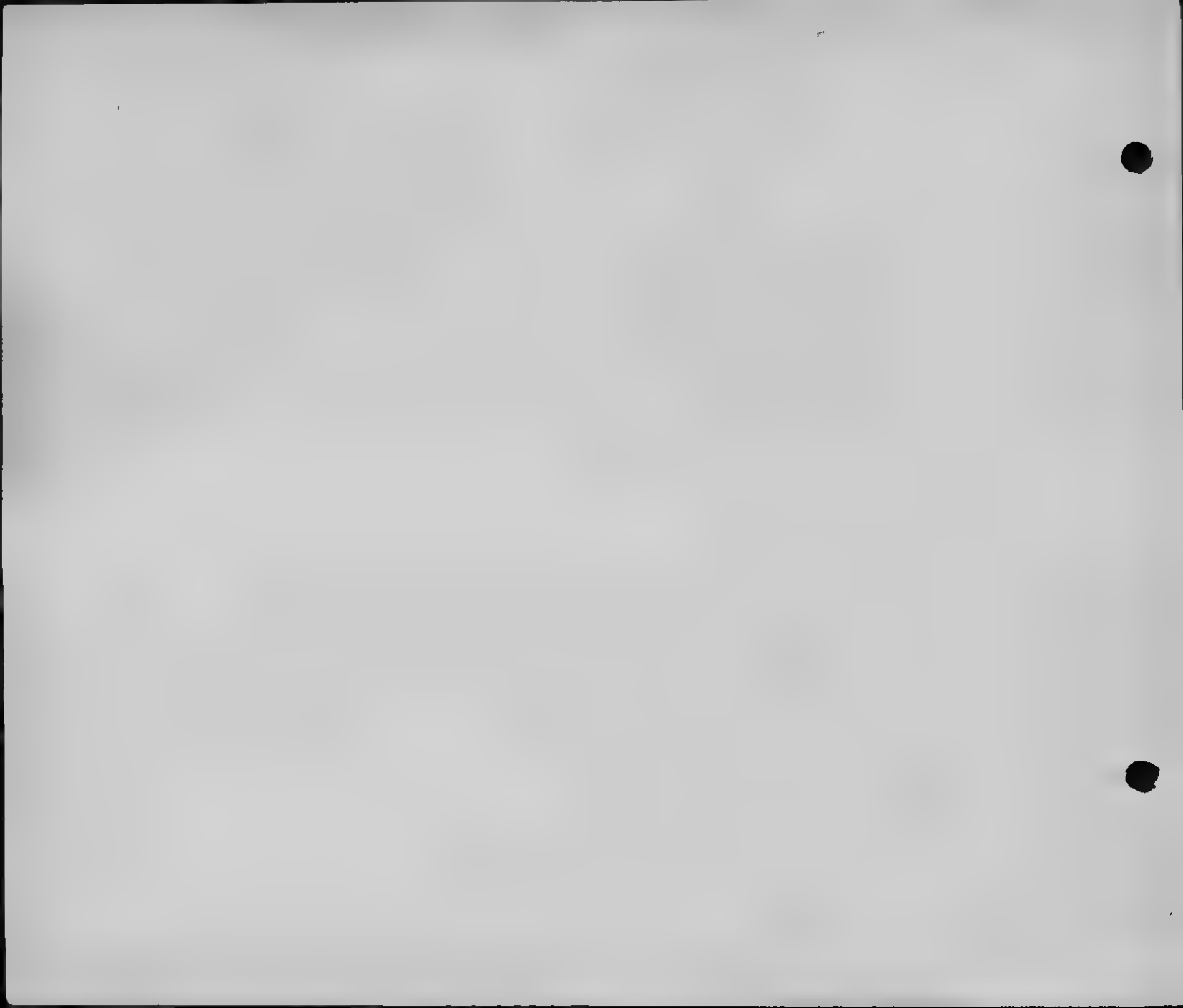
CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH - COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>P.O. Glen Burnie</i>				CITY (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>			
TOWN <i>P.O. Glen Burnie</i> LENGTH OF STAY (In this place) <i>4 years</i>				TOWN <i>Laurel</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Point Pleasant</i>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <i>Charles A. Boone Jr</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>March 28 1955</i>			
5. SEX <i>M.</i>		6. COLOR OR RACE <i>W.</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Married</i>		8. DATE OF BIRTH <i>7/5/07</i>	
9. AGE last birthday <i>47</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician for R. & E. Electric Lines Service</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore - Md.</i>	
13. FATHER'S NAME <i>Charles A. Boone</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>218-09-8184</i>		17. INFORMANT AND ADDRESS <i>Mr. N. Boone (Wife)</i>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>420. Immediate cause (a) <i>Coronary Occlusion</i> Interval Between Onset and Death <i>Sudden</i></p> <p>Antecedent cause(s) (b) _____</p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____</p>							
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
TIME (Month) (Day) (Year) (Hour) OF INJURY				PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY			
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, or thereon and from the evidence obtained by Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes, accident, suicide, homicide, undetermined.							
SIGNATURE <i>Pauline A. Pauter</i>				DATE SIGNED <i>3/28/55</i>			
(Degree or title)				ADDRESS <i>M.D. Glen Burnie, Md.</i>			
23. CREMATION		DATE THEREOF <i>3/30/55</i>		NAME OF CEMETERY OR CREMATORY <i>London Park</i>		LOCATION (City, town, or county) (State) <i>Balto. 17, Md.</i>	
DATE FILED BY LOCAL REG. <i>3-29-55</i>		REGISTRAR'S SIGNATURE <i>Dr. J. J. Vicianey</i>		24. FUNERAL DIRECTOR'S ADDRESS <i>Wm. J. Vicianey & Sons, Balto. 17, Md.</i>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this, certificate has been executed by the attending physician, and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2239

CERTIFICATE OF DEATH

02228

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A A</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNAPOLIS</u>				TOWN <u>ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>104 MARKET</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>JAMES EDWIN BRENNEMAN</u>				(Month) (Day) (Year) <u>3-10-1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>1-17-1881</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>CLERK</u>			<u>U.S. NAVAL ACADEMY</u>		<u>PA</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>LEWIS ALBERT BRENNEMAN</u>				<u>JANE SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>CYNTHIA M. BRENNEMAN</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						16. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>✓</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1955</u> , to <u>10 Mar 1955</u> , that I last saw the deceased alive on <u>10 Mar 1955</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Edward A Beck</u>		<u>4 Southgate Ave Annapolis</u>		<u>3/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>3-14-55</u>		<u>New Harmony Cemt</u>		<u>York Co. Penn</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>March 11, 1955</u>		<u>J. J. Daniel</u>		<u>John W. Taylor Sons</u>		<u>Annapolis Md</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2264 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02229

CERTIFICATE OF DEATH

Reg. Dist. No. 22

Item 12. File GL&O 4-15-55 et

1. PLACE OF DEATH: COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL and give nearest town) Jessup TOWN Jessup HOSPITAL OR INSTITUTION OR STREET ADDRESS Maryland House of Correction		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY Stockton, Md. CITY (If outside corporate limits, write RURAL and give nearest town) Jessup, Maryland TOWN Jessup, Maryland STREET ADDRESS (If rural, give location) Jessup, Maryland	
3. NAME OF DECEASED (Type or Print) Charles		4. DATE OF DEATH (Month) March (Day) 7th. (Year) 1955	
5. SEX male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married	8. DATE OF BIRTH Dec. 25, 1900
9. AGE last birthday 54 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Chile		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War I		16. SOCIAL SECURITY NO. I	
17. INFORMANT AND ADDRESS Md. House of Correction			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X Immediate cause

(a) **Carcinoma of Stomach with**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **metastases**

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **8-15**, 1954, to **3-7**, 1955, that I last saw the deceasedalive on **3-6**, 1955, and that death occurred at **6:45 A.M.**, from the causes and on the date stated above.SIGNATURE **Robert B. Taylor MD** ADDRESS **Maryland House of Correction, Md.** DATE SIGNED

23. BURIAL, CREMATION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3/16/55	St. Mary's Hospital	Baltimore, Md.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
3/16/55	Wanda Wood	Mrs. F. H. Hensley	378 W. Gullible St.	

S A P

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2265 CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel MARYLAND				STATE Maryland COUNTY Caroline			
CITY (If outside corporate limits, write RURAL OR and give nearest town), TOWN X Crownsville				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Greensboro 05X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital				STREET ADDRESS (If rural give location) None listed			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Dennis Brown				4. DATE OF DEATH (Month) (Day) (Year) 3 8 19 55			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 3/4/1891	9. AGE last birthday 64 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. 219-14-4966 Unk.		17. INFORMANT & ADDRESS Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) Myocardial Insufficiency						INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive cardiovascular Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. el work <input type="checkbox"/> Not while el work <input type="checkbox"/>		21e. INJURY OCCURRED While el work <input type="checkbox"/> Not while el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/29/1954 to 3/8/1955, that I last saw the deceased alive on 3/8/1955, and that death occurred at M. from the causes and on the date stated above.							
SIGNATURE L. Benedict		M.D.		ADDRESS (Street, city, town, state) Crownsville, Md.		DATE SIGNED 3/8/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/12/55		NAME OF CEMETERY OR CREMATORY Union		LOCATION (City, town, or county) (State) Goldsboro Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE H. J. 3400		25. FUNERAL DIRECTOR'S SIGNATURE J. E. Bowles		ADDRESS Greensboro, Md.	
DATE 3-12-55							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

F. B. BUREAU

MAR 16 1955

15. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2266

CERTIFICATE OF DEATH

02231

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MD</u>		COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Shady Side</u>		<u>25 yrs</u>		TOWN <u>Shady Side</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Thomas</u> (Middle) <u>Busser</u> (Last)				<u>3rd</u> <u>5th</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Single</u>	<u>MAY 4 1896</u>	<u>58</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Tobacco</u>		<u>Churchton</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert H. Bussey</u>				<u>Queenie Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Katherine F. Schmick</u> <u>ARNOLD MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
150X IMMEDIATE CAUSE (A) <u>Hemorrhage - esophageal</u>						<u>18 Hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma - esophagus</u>						<u>6 Mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>11</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>12-14</u> , 19 <u>54</u> , to <u>3-4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-4</u> , 19 <u>55</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. <u>3-5-55</u>							
SIGNATURE <u>F O Hendrichs</u>				ADDRESS (Street, city, town, state) <u>Shady Side, Maryland</u>			
DATE SIGNED <u>3-5-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/7/55</u>		<u>200ker</u>		<u>Laureville MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Mar. 9, 1955</u>		<u>Ida Bell Dent</u>		<u>Bernard Hardisty</u>		<u>Laureville MD</u>	

2267

CERTIFICATE OF DEATH

02232

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		<u>3✓01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>439 W. Henrietta Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u>		(Middle) <u>Frances</u>		(Last) <u>Carr</u>		DATE (Month) (Day) (Year) <u>3 5 19 55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1884?</u>		9. AGE last birthday <u>71?</u> yrs.		10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Known to us since <u>3/3/55</u>			
IMMEDIATE CAUSE (A) <u>Uremia</u>				II			
ANTECEDENT CAUSE(S) DUE TO <u>Chronic Pyonephrosis</u>				II			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Gangrenous urinary cystitis</u>				II			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Brain Disease</u>				II			
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/3</u> , 19 <u>55</u> , to <u>3/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/5</u> , 19 <u>55</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict</u>		(L. Benedict, M. D.)		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>3/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>3/9/55</u>		REGISTRAR'S SIGNATURE <u>E. W. Benedict</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Street</u>			

VS AISC 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

RECEIVED
K. R.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 11 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2240

CERTIFICATE OF DEATH

02233

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anna Arundel		MARYLAND		STATE Md.		COUNTY Baltimore,	
CITY (If outside corporate limits, write RURAL and give nearest town) 10 TOWN Annapolis,		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Riderwood,		3X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anna Arundel General Hospital				STREET ADDRESS (If rural give location) W. Joppa Road			
3. NAME OF DECEASED (Type or Print) Stuart M. Christhlf				4. DATE OF DEATH (Month) (Day) (Year) March 16, 19 55			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Nov. 4, 1889	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distributor - Construction & Industrial		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry B. Christhlf				14. MOTHER'S MAIDEN NAME Anna M. O. Gill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS 1708 Circle Road Mr. Bryson Christhlf Ruxton-4, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443 ^x IMMEDIATE CAUSE (A) Rupture of dissecting aortic aneurysm							
ANTECEDENT CAUSE(S) DUE TO (B) atherosclerosis of aorta						5 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic-Hypertensive CVD						5 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/12/1955 , to 3/16/1955 , that I last saw the deceased alive on 3/16/1955 , and that death occurred at 3:25 P.M. from the causes and on the date stated above.							
SIGNATURE Frank McElroy				ADDRESS (Street, city, town, state) Annapolis Md. DATE SIGNED 3/16/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 19, 1955		NAME OF CEMETERY OR CREMATORY Druid Ridge		LOCATION (City, town, or county) (State) Pikesville, Md.	
24. REC'D BY REGISTRAR DATE 3/21/55		REGISTRAR'S SIGNATURE John O. Mitchell		25. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons ADDRESS 1900 Rutaw Place			

RECEIVED W.S.

1918

RECEIVED
JAN 20 1918

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2268 **CERTIFICATE OF DEATH**

02234

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Anne Arundel</u>			
CITY OR TOWN <u>POWHATAN BEACH</u>		LENGTH OF STAY (in this place) <u>6 yrs.</u>		CITY OR TOWN <u>POWHATAN BEACH</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. 3 PASEDENA</u>				STREET ADDRESS <u>R.F.D. 3 PASEDENA</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>HOMER BUTTS CLARK</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 2 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Feb. 19, 1877 (approx.)</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSIT CO.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARK</u>				14. MOTHER'S MAIDEN NAME <u>Judith Hammond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Thomas H. CLARK 7517 BELAIR Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19</u> to <u>19</u> that I last saw the deceased alive on <u>19</u> and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>LOUIS J. DALBY</u> M.D. <u>102 BALTO. AVE. BALTO. MD.</u> DATE SIGNED <u>3/2/55</u> <u>GLEN BURNIE N.E. Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
24. RECEIVED BY REGISTRAR <u>Mar. 8, 1955</u>		REGISTRAR'S SIGNATURE <u>Louis J. Dalby</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schmitt</u>		ADDRESS <u>2101 Frederick Ave.</u>	

BLIND N 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2269

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02235
Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>h.h. Co.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>h.h. Co.</u>	
CITY (If outside corporate limits, write RURAL OR give nearest town) TOWN <u>Mayo</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Mayo, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Mayo, Md.</u>			
3. NAME OF DECEASED: (Type or Print) <u>KARLINE OBERG COLLISON</u>				4. DATE OF DEATH <u>3 7 19 55</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>3/4/1886</u>	
9. AGE last birthday: <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Wesley Dawson</u>				14. MOTHER'S MAIDEN NAME: <u>Josephine Ober OBERG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>1</u>		16. SOCIAL SECURITY No.: <u>1</u>		17. INFORMANT & ADDRESS: <u>Harry Collison</u> <u>AK</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a)..... <u>420.1 Coronary Arteriosclerosis</u>							
DUE TO							
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause (c).....							
stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>3/10/55</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town), (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Edward Collison</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/8/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>3/10/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Mayo Memorial</u>		LOCATION (City, town, or county) (State): <u>Mayo Md.</u>	
DATE REC'D BY LOCAL REG. <u>March 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Edward Collison</u>		24. FUNERAL DIRECTOR <u>John M. Taylor and Son</u>		ADDRESS <u>Annapolis, Md.</u>	



2270

CERTIFICATE OF DEATH

02236

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Pt. Pleasant</u>				TOWN <u>Pt. Pleasant</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Barbara</u> (Middle) <u>Mary</u> (Last) <u>Cunningham</u>				(Month) <u>3</u> (Day) <u>3</u> (Year) <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS
F	W	M	12/22/90	64 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housework			Home		Baltimore		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Michael J. Zant				Barbara M. Wise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No						Family - Same	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1. IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>							
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma Colon</u>						1 year	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
2							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept Mar 19 54</u> to <u>March 19 55</u> , that I last saw the deceased alive on <u>2-26</u> , 19 <u>55</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bill Mac Donald</u>				ADDRESS (Street, city, town, state) <u>Essex Burial Md</u>		DATE SIGNED <u>3-3-55</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, of county) (State)	
B		3/8/55		Cathedral		Baltimore Md	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Mar. 7, 1955</u>		<u>L. J. Sealy</u>		<u>James L. McCully</u>		<u>130 E. Fort Ave.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

STANDARD

1915

1915

2271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

X

TOWN

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

STREET
ADDRESS

(If rural give location)

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

8. DATE OF BIRTH:

4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

9. AGE last
birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

yrs. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if retired:10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTH PLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY:

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X
Immediate cause

(a) DUE TO

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

Interval Between
Onset And Death

3 hrs

5 yrs.

3 yrs

15 yrs

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY m.INJURY OCCURRED
While at Not While
Work ☐ At Work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/15, 1954 to 3/15, 1955 that I last saw the deceased

alive on 3/15, 1955, and that death occurred at 3 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or co. and state)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

U.S. AIR FORCE

100-100000

2241

MARYLAND STATE DEPARTMENT OF HEALTH

02238

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Linden</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>15X-2</u>	
3. NAME OF DECEASED (Type or Print) <u>Richard Ralph Davis</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>24</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Sept. 23, 1914</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Repair Operator</u>	9b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>40</u> yrs.	10. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
11. FATHER'S NAME <u>Glysses Brown</u>		12. MOTHER'S MAIDEN NAME <u>Georganna Davis</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		14. SOCIAL SECURITY No. <u>W-11</u>	
15. INFORMANT AND ADDRESS <u>Elizabeth Davis - Linden, Md.</u>			

16. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Fracture Cervical Vert. C Compression of Spine</u>		
Antecedent cause(s) (b) <u>of Spine</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

17. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Highway</u>	(CITY OR TOWN) <u>12</u> (COUNTY) <u>AAEO</u> (STATE) <u>MD.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3</u> <u>24</u> <u>55</u> P. m.	INJURY OCCURRED While at <input checked="" type="checkbox"/> work Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Free fall - over Patient</u>

22. I certify that I took charge of the remains described above, held an Autopsy Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> <u>accident</u> <input type="checkbox"/> <u>suicide</u> <input type="checkbox"/> <u>homicide</u> <input type="checkbox"/> <u>undetermined</u> <input type="checkbox"/>			
SIGNATURE <u>Paul Ladd</u>		DATE SIGNED <u>3/24/55</u>	
23. BURIAL, CREMATION OR MOVIAL (Specify)	DATE THEREOF <u>3-28-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Hall</u>	LOCATION (City, town, or country) (State) <u>Arlington, Va.</u>
DATE REC'D BY LOCAL REG. <u>March 25, 1955</u>	REGISTRARS SIGNATURE <u>W. O. Brown</u>	24. FUNERAL DIRECTOR <u>William Reese, Jr.</u>	ADDRESS <u>108 Washington St. Annapolis, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2272

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AnneArundel</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>		CITY OR TOWN <u>Baltimore City</u>		CITY OR TOWN <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY OR TOWN <u>3661 4</u>	
TOWN <u>Crownsville</u>		<u>4yrs.7mos.5days</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				<u>1713 Pierce Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Emma</u> (First) <u>Derricks</u> (Middle) (Last)				<u>3</u> (Month) <u>3</u> (Day) <u>19 55</u> (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>9/11/04</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Epilepsy</u>				Known to us since <u>7/26/50</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>---</u>		<u>---</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>---</u>		<u>---</u>		<u>---</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>---</u>		<u>---</u>		<u>---</u>			
22. I hereby certify that I attended the deceased from <u>7/26</u> , 19 <u>50</u> , <u>3/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/3</u> , 19 <u>55</u> , and that death occurred at <u>1:10p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>(L. Benedict, M. D)</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>West. Glen Cem</u>		LOCATION (City, town, or county) (State) <u>Balto. Co. Md</u>	
24. REC'D BY REGISTRAR <u>---</u>		REGISTRAR'S SIGNATURE <u>---</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan Jr</u>		ADDRESS <u>Balto.</u>	
DATE <u>3-8-55</u>							

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

8

1977

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02240

2273

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>				STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crownsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rhodesdale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>R. F. D.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Parley</u> (Middle) <u>L.</u> (Last) <u>Dockins</u>				DATE (Month) (Day) (Year) <u>3</u> <u>6</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		
<u>Female</u>	<u>Negro</u>	<u>Married</u>	<u>11/4/95</u>	<u>59</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						<u>Maryland</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Moses Ferrell</u>				<u>Alonza Ferrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Unk.</u>				<u>Unk.</u>		<u>Hospital Records</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>443X</u>				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				<u>Known to us since</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>2/10/55</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Hypertension and Arteriosclerotic cardiovascular</u>			
STATING UNDERLYING CAUSE LAST, DUE TO				<u>disease</u>			
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>55</u> , to <u>3/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/6</u> , 19 <u>55</u> , and that death occurred at <u>12:20p</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
DATE <u>3-7-55</u>				DATE <u>3/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>3/9/55</u>		<u>Thompsontown Cemetery</u>		<u>Thompsontown, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
		<u>[Signature]</u>		<u>[Signature]</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE A15C 1-55 10M

STANDARD M. S.

10 2 10

10 2 10

2274

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Winchester</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Winchester</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Carrie</i> (Middle) <i>Bersch</i> (Last) <i>Fischer</i>		(Month) <i>3</i> (Day) <i>12</i> (Year) <i>1955</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Nov. 26, 1867</i>
9. AGE last birthday <i>87</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Carl Bersch</i>	
14. MOTHER'S MAIDEN NAME <i>Angelica Bode</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <i>No</i> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mrs. Gerda Vey #2</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
2. IMMEDIATE CAUSE (A) <i>Embolism to brain, rt. ventricle by</i>			<i>5 days</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis C.C.U.</i>			<i>yr.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>3</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>M.</i>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan. 1955</i> to <i>3/12/55</i> , that I last saw the deceased alive on <i>3/12/55</i> , and that death occurred at <i>8:05 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Frank M. Shufly</i>		DATE SIGNED <i>3/14/55</i>	
ADDRESS (Street, city, town, state)		M.D. <i>Annapolis</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-16-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Presbyterian Cent</i>		LOCATION (City, town, or county) <i>Groves, Balto Md</i>	
24. REC'D BY REGISTRAR <i>John M. Taylor</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>	
DATE <i>March 14, 1955</i>		ADDRESS <i>Annapolis Md</i>	

VS A15C 1-55 10M

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

RECEIVED

MAR 15 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2275

02243

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>AA</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>AA</u>
CITY OR TOWN <u>Nutwell</u>	LENGTH OF STAY (in this place) <u>63 yrs</u>	CITY OR TOWN <u>Nutwell</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (if rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Thomas</u> (Middle) <u>Luther</u> (Last) <u>Ford</u>		(Month) <u>MAR</u> (Day) <u>11</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>OCT 13 1871</u>
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	
11. BIRTHPLACE (State or foreign country) <u>TRACYS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Ford</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES Perry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS <u>Susie R Ford, Nutwell, MD</u>			
15. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			16. MEDICAL CERTIFICATION
442X IMMEDIATE CAUSE (A) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>			
17. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 24</u> , 19 <u>55</u> , to <u>Mar 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Mar 11</u> , 19 <u>55</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>[Address]</u> DATE SIGNED <u>[Date]</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/13/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>Friendship MD</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>[Address]</u>	
DATE <u>3/12/55</u>			

MAR 15 1955

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02244

2276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>4 A</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>A A</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNA</u>				TOWN <u>HILLSMEDE SHORES</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RIVA CONVALESCENCE HOME</u>				STREET ADDRESS (If rural give location) <u>ANNAPOLIS R.F.D. MD 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SADIE</u> (Middle) <u>K</u> (Last) <u>FULTON</u>				(Month) <u>3</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOW</u>		8. DATE OF BIRTH <u>5-13-1867</u>	
				9. AGE last birthday <u>87</u> yrs.		IF UNDER 1 YEAR	
						Months Days	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PITTSBURGH PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY P. KREBS</u>				14. MOTHER'S MAIDEN NAME <u>SARAH PALMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Bessie Bruce</u> <u>Mr Morris Knowles Hillmore md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>cerebral hemorrhage</u>				<u>2 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>gen arteriosclerosis</u>			
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/19</u> , 19 <u>55</u> , to <u>3/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>55</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>S Brown</u> M.D.				ADDRESS (Street, city, town, state) <u>Annapolis md</u>			
DATE <u>March 31, 1955</u>				DATE SIGNED <u>3/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3-31-55</u>		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) <u>Pittsburgh Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Collinson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lay</u>		ADDRESS <u>Laurel Annapolis Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

4p.

2277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>4 mos. 8 days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>10 Crownsville State Hospital</u>				<u>652 W. Franklin Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE DEATH			
(First) <u>Leetta</u> (Middle) <u>Evelyn</u> (Last) <u>Gibbs</u>				(Month) <u>3</u> (Day) <u>24</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Negro</u>	<u>Divorced</u>	<u>8/15/11</u>	<u>43</u> yrs.	Months <u>-</u> Days <u>-</u>	Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Unknown</u>		<u>Ohio</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Mack Preston</u>				<u>Rosetta Ealy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>2 days</u>	
782.4 IMMEDIATE CAUSE (A) <u>Acute heart failure</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/16</u> , 19 <u>54</u> , to <u>3/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/24</u> , 19 <u>55</u> , and that death occurred at <u>5:30a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict, M. D.</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/28/55</u>		<u>Mt Auburn Cem.</u>		<u>Balto, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>3-25-55</u>		<u>Lathen M. Joyce</u>		<u>A. H. ...</u>		<u>...</u>	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

2278

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

02246

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1810 Etting St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Annie Gray</u>				4. DATE OF DEATH March 26 19 55			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Ne ro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>10/12/78</u>	
9. AGE last birthday <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME <u>unk</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>			
16. SOCIAL SECURITY NO. <u>unk</u>				17. INFORMANT & ADDRESS <u>hospital Record</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Cerebrovascular Accident (Hemorrhage)</u>							9 days
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive & Arteriosclerotic Cardiovascular D's.</u>							years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized & Cerebral Arteriosclerosis</u>							years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>2/16/55</u> , 19 <u>55</u> , to <u>3/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/26</u> , 19 <u>55</u> , and that death occurred at <u>6:30 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stanley A. Sargent</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Mar 30/55</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore Md.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR DATE <u>3/24/55</u>		REGISTRAR'S SIGNATURE <u>Louise M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Ruggold</u>		ADDRESS <u>1463 N. Carey</u>	

U.S. AIR FORCE

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RECEIVED

2279

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town.) <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>11 mos. 29 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		<u>3/01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1718 W. Lafayette Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Jeanette S. Green</u>				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>2</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>12/5/74</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> - - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Thomas J. Hilliard</u>				14. MOTHER'S MAIDEN NAME <u>Harriet N. Hilliard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>450.0</u> IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Known to us since 3/4/54</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u> </u>				<u> </u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u>				<u> </u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u> </u>							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <u> </u>		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>		<u> </u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u> </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u> </u>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>3/4</u> , 19 <u>54</u> , to <u>3/2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/2</u> , 19 <u>55</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above. SIGNATURE <u>(Dr. Benedict)</u> DATE SIGNED <u>3/2/55</u> <u>Crownsville, Md.</u>							
23. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u> </u>		DATE THEREOF <u>3/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		LOCATION (City, town, or county) (State) <u>Baltimore City, Maryland</u>	
24. REC'D BY REGISTRAR <u>Mar. 8, 1955</u>		REGISTRAR'S SIGNATURE <u>(Signature)</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arlington S. Phillips</u> <u>1808 N. Monroe St. Balto. 17. Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MAR 8 1955

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U.S. DEPT. OF JUSTICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2280 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02248

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 8, File 6179 4-1-55 et

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hamover</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hamover Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Elbridge Landing Rd</u>		STREET ADDRESS (If rural, give location) <u>Elbridge Landing Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Rachel Mariah Greene</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 22 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 15, 1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTH PLACE (State or foreign country) <u>Anne Arundel Co</u>
13. FATHER'S NAME <u>Nicholas Greene</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Andrew, No</u>		18. INFORMANT AND ADDRESS <u>Elgenea Shandy, Lenthcin Hgts Md</u>	
15. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
4221 Immediate cause (a) <u>Acute Myocarditis</u>			<u>6 mo</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Dehydration</u>			<u>2 mo</u>
(c) <u>General arterio-sclerosis</u>			<u>3 yrs</u>
<u>Sensibility</u>			<u>3 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 20, 1955</u> , to <u>March 22, 1955</u> , that I last saw the deceased alive on <u>March 21, 1955</u> , and that death occurred at <u>2:25</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Dr B B Brumbaugh</u>		DATE SIGNED <u>3/22/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/25/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cem</u>		LOCATION (City, town, or county) (State) <u>Harmons Md</u>	
DATE REC'D BY LOCAL REG <u>3/25/55</u>		24. FUNERAL DIRECTOR <u>Mrs Kate R Williams</u> ADDRESS <u>Schreder St</u>	



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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2242

02249

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>AA</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN		TOWN	
TOWN <u>Annapolis, Maryland</u>		<u>2 days</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital, Annapolis</u>				<u>29 Badger Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u> (Middle) <u>Arthur</u> (Last) <u>GREGORY</u>				(Month) <u>March</u> (Day) <u>6</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>C</u>	<u>M</u>	<u>9-11-28</u>	<u>27</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>USN</u>		<u>USN</u>		<u>S.C.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Arthur Gregory Sr.</u>				<u>Agness Jeffers Stackhouse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>				<u>U.S.N.H Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>Ind.</u>	
IMMEDIATE CAUSE (A) <u>Tumor, Brain (#193) Ependymoma</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>3-7-55</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-7-55</u> , 19 <u>55</u> , to <u>3-7-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-7-55</u> , 19 <u>55</u> , and that death occurred at <u>8:40M</u> , from the causes and on the date stated above.							
SIGNATURE <u>R.H. Brown</u>				ADDRESS (Street, city, town, state)			
<u>R.H. BROWN LCDR MC USN</u>				<u>USNH, Annapolis, Md.</u>			
DATE THEREOF <u>3-7-55</u>				DATE SIGNED <u>3-6-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>REMOVAL</u>				<u>GRIFFIN, GA.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3-7-1955</u>		<u>[Signature]</u>		<u>B.L. Hopping and Son</u>		<u>Annapolis, Md.</u>	

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2243

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>AA</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>AA</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AA GENERAL Hospt</u>		STREET ADDRESS (If rural give location) <u>138 CHARLES</u>	
3. NAME OF DECEASED (Type or Print) <u>ELLEN KEY HABERSHAM</u>		4. DATE OF DEATH <u>3-10-1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>SINGLE</u>	8. DATE OF BIRTH <u>NOV. 23-1870</u>
9. AGE last birthday <u>84</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>ALEXANDER WYLLY HABERSHAM</u>	
14. MOTHER'S MAIDEN NAME <u>JESSIE STEELE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>MRS FOSTER HANNAFORD (2)</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		SECONDS	
162x IMMEDIATE CAUSE (A) <u>TRACHEAL OBSTRUCTION</u>		SEVERAL MONTHS	
ANTECEDENT CAUSE(S) DUE TO (B) <u>MALIGNANCY OF TRACHEA</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>CARCINOMA OF TRACHEA</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>REHABILITATION</u>			
19a. DATE OF OPERATION <u>10 MARCH 55</u>		19b. MAJOR FINDINGS OF OPERATION <u>TUMOR OF TRACHEA (CARCINOMA)</u>	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M. 59</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7 MARCH 1955</u> , to <u>10 MARCH 55</u> , that I last saw the deceased alive on <u>10 MARCH 1955</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. B. Reddy</u>		DATE SIGNED <u>11 MARCH 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>J. B. Reddy</u>	
DATE <u>March 14, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

MAR 15 1975

BUREAU

2281

02251

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL, LENGTH OF STAY
OR and give nearest town) (in this place)
☒ TOWN Severn All life
HOSPITAL OR
INSTITUTION OR
STREET ADDRESS Queenstown Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Same COUNTY Same
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Same
STREET ADDRESS (If rural give location)
Same

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Edward

Hall

5. SEX:

M.

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): Widowed?

8. DATE OF BIRTH:

4. DATE OF DEATH:

(Month)

(Day)

(Year)

March 15

19 55

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hour Min.
78 yrs.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired.
Retired labor.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Severn, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Jerry Hall

14. MOTHER'S MAIDEN NAME:

Lille Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No

16. SOCIAL SECURITY No.:

No

17. INFORMANT & ADDRESS:

Asahall Hall (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause

(a) DUE TO

Hypertensive cardio vascular diseases

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

Acute prostatitis

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

Interval Between Onset And Death

??

?

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/2/55, 1955, to 3/15/55, 1955, that I last saw the deceased

alive on 3/10/55 1955

and that death occurred at 8 A.M.

from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REBURYAL (Specify)
Burial
DATE REC'D BY LOCAL REGISTRAR
3/15/55

DATE THEREOF

3/15/55

NAME OF CEMETERY OR CREMATORY

St. Catharine

LOCATION (City, town, or county)

Brooklyn - Maryland

(State)

REGISTRAR'S SIGNATURE

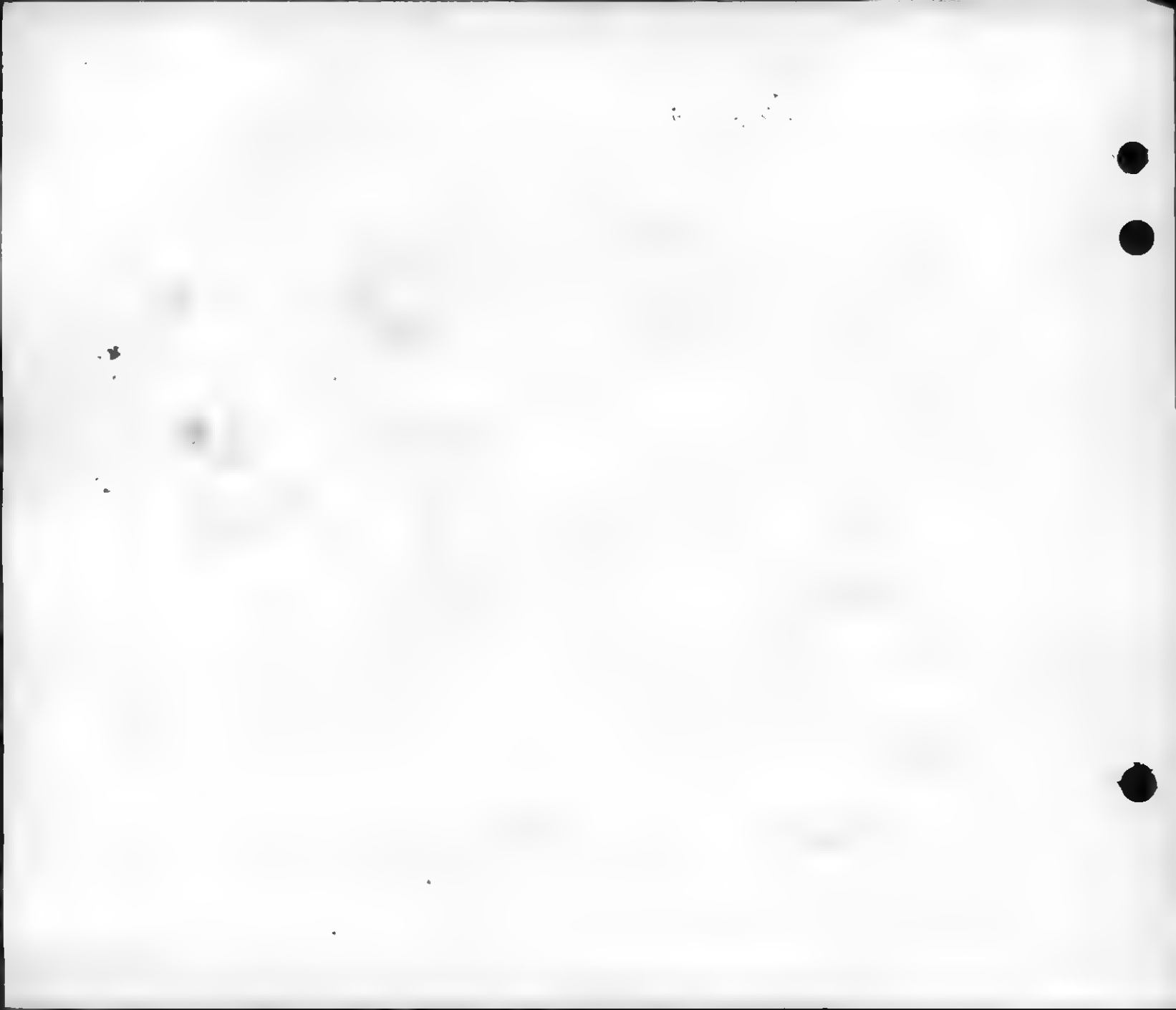
24. FUNERAL DIRECTOR

Marshall P. Hayes 638 N. Belmor

Dr. J. J.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2244

CERTIFICATE OF DEATH

02252

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		50 Yrs.		TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
76 Franklin Street				76 Franklin Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>CARRIE OLIVIA HARDESTY</u>				<u>3/14/1955</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Married</u>	<u>March 6, 1893</u>	<u>52</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>None</u>		<u>Galesville A.A. Co. Maryland</u>		<u>-----</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Turner</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Annapolis, Maryland</u> <u>Walter Hardesty-76 Franklin Street</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE (A) <u>Carcinoma of the Recto-Sigmoid</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Portion of the large intestine</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>3/14/55</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 12, 1955</u> to <u>March 14, 1955</u> , that I last saw the deceased alive on <u>3/14</u> , 19 <u>55</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter Hardesty</u>		M.D. <u>110-Clay Street Annapolis</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>3/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 15, 1955</u>		<u>Brewer Hill Cemetery</u>		<u>West St. Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>March 15, 1955</u>		<u>W. O. Daniel</u>		<u>Edhel L. Ticks-45 Northwest St. Annapolis</u>		<u>Maryland</u>	

LIBRARY

MAR 16 1955

100-100000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
2245

02253

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>1 day</u>		TOWN <u>Galesville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>OSCAR Emile Hartge</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 30 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug 3 1875</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <u>Marine Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARINE</u>		11. BIRTHPLACE (State or foreign country) <u>Shadyside MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Emile Alexander Hartge</u>				14. MOTHER'S MAIDEN NAME <u>Susan V. Edgar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>388 20 5087</u>		17. INFORMANT & ADDRESS <u>Wanda Strong, Galesville MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Diabetic Coma</u>				<u>12 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarction?</u>				<u>12 hr</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTO-PSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY-street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/29</u> , 19 <u>55</u> , to <u>3/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>55</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank McKelley</u>				ADDRESS (Street, city, town, state) <u>Annapolis</u> DATE SIGNED <u>3/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/1/55</u>		NAME OF CEMETERY OR CREMATORY <u>Luther</u>		LOCATION (City, town, or county) (State) <u>Galesville Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>U. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Galesville Md</u>	
DATE <u>April 1, 1955</u>							

LIBRARY N. 2

100

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNAPOLIS</u>		MARYLAND		STATE <u>MD</u> COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. GENERAL</u>				STREET ADDRESS (If rural give location) <u>DEFENCE HIGHWAY</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>C</u>		(Middle) <u>ADDISON</u>		(Last) <u>HODGES</u>		(Month) <u>3</u> (Day) <u>28</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPECIFY <u>MARRIED</u>	8. DATE OF BIRTH <u>4-3-1885</u>	9. AGE last birthday <u>69</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROBATION OFFICER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN THOMAS HODGES</u>				14. MOTHER'S MAIDEN NAME <u>IDA KENT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>JOHN HODGES DAVIDSONVILLE MD</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
540.1 IMMEDIATE CAUSE (A) <u>peritonitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rupture + necrosis transverse colon</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Gastric ulcer</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Mar 15 - 26</u>		19b. MAJOR FINDINGS OF OPERATION <u>gastric ulcer, 2 necrosis transverse colon</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-17</u> , 19 <u>54</u> , to <u>3-28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-27</u> , 19 <u>55</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above							
SIGNATURE <u>South Pooler</u>		DATE THEREOF <u>Mar 29 1955</u>		NAME OF CEMETERY OR CREMATORY <u>All Hall's Chapel</u>		LOCATION (City, town, or county) (State) <u>Davidsonville Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>J. J. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Annapolis Md</u>	
DATE <u>March 29, 1955</u>							

INSTRUCTIONS

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VS AISC 1-55 10M



1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2282

CERTIFICATE OF DEATH

02255

Reg. Dist. No. 28

Item 9, Film G178 3-16-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		CITY OR TOWN Gambrills		STATE Maryland		COUNTY Anne Arundel	
HOSPITAL OR INSTITUTION OR STREET ADDRESS "Rose Hill"		LENGTH OF STAY (in this place)		CITY OR TOWN Gambrills		STREET ADDRESS (If rural give location) "Rose Hill"	
3. NAME OF DECEASED (First) (Middle) (Last) MATILDA DARE HOPKINS				4. DATE OF DEATH (Month) (Day) (Year) March 1, 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH April 30, 1880		9. AGE last birthday 74 1/2 yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Gambrills, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Snowden Hopkins				14. MOTHER'S MAIDEN NAME Matilda Elizabeth Matilda			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) none		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mr. C. Edward Hopkins, same as # 2			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 170x IMMEDIATE CAUSE (A) <u>Adenocarcinoma - Lt Breast</u>				INTERVAL BETWEEN ONSET AND DEATH 6 MO			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 1, 1946, to Mar. 1, 1955, that I last saw the deceased alive on Mar. 1, 1955, and that death occurred at 9:40 A.M. from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF March 3, 55		NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery	
24. REC'D BY REGISTRAR DATE 3-4-55				REGISTRAR'S SIGNATURE Kim S. S.		25. FUNERAL DIRECTOR'S SIGNATURE Ben L. Hopping and Son	
26. ADDRESS (Street, city, town, state) Gambrills				DATE SIGNED 3-2-55			
27. LOCATION (City, town, or county) Millersville, Maryland				28. ADDRESS			

JOHN V. S.

1955 3

NEW

CERTIFICATE OF DEATH

Reg. Dist. No. *2283*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>ANNE ARUNDEL</i>	MARYLAND	STATE <i>MD.</i>	COUNTY <i>ANNE ARUNDEL</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR <i>ROUTE #3 - ANNAPOLIS</i>	LENGTH OF STAY (in this place) <i>2 WKS.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <i>ROUTE #3 - ANNAPOLIS</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>WILD ROSE SHORES</i>		STREET ADDRESS (If rural give location) <i>WILD ROSE SHORES</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print)	<i>ADA LOUISE HOYE</i>	(Month) (Day) (Year)	<i>MARCH 8 1955</i>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<i>FEMALE</i>	<i>WHITE</i>	<i>WIDOWED</i>	<i>FEB 7/1871</i>
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country):
<i>HOUSEWIFE</i>		<i>AT HOME</i>	<i>FLAT ROCK, MICH.</i>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>GEORGE MILTON READING</i>		<i>FLORENCE MIGHLES</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
<i>NO</i>		<i>NONE</i>	<i>GEORGE G. HOYE-ROUTE #3-ANNAPOLIS MD.</i>
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
<i>151X</i> Immediate cause (a) <i>Possible Gastric Carcinoma</i>			<i>unknown</i>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b)			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
<i>6</i>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>3-8</i> , 1955, to <i>3-8</i> , 1955, that I last saw the deceased alive on <i>3-8</i> , 1955, and that death occurred at <i>2:45 PM</i> from the causes and on the date stated above.			
SIGNATURE		ADDRESS	DATE SIGNED
<i>E. Edward Beck</i>		<i>4 Saintgate Ave Annapolis</i>	<i>3-8-55</i>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>3/11/1955</i>	<i>Cedar Hill Cemetery</i>	<i>San Land Md.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>March 9, 1955</i>	<i>James Severy</i>	<i>W.W. CHAMBERS Co - RIVERDALE MD.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 1/2 years

of land

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

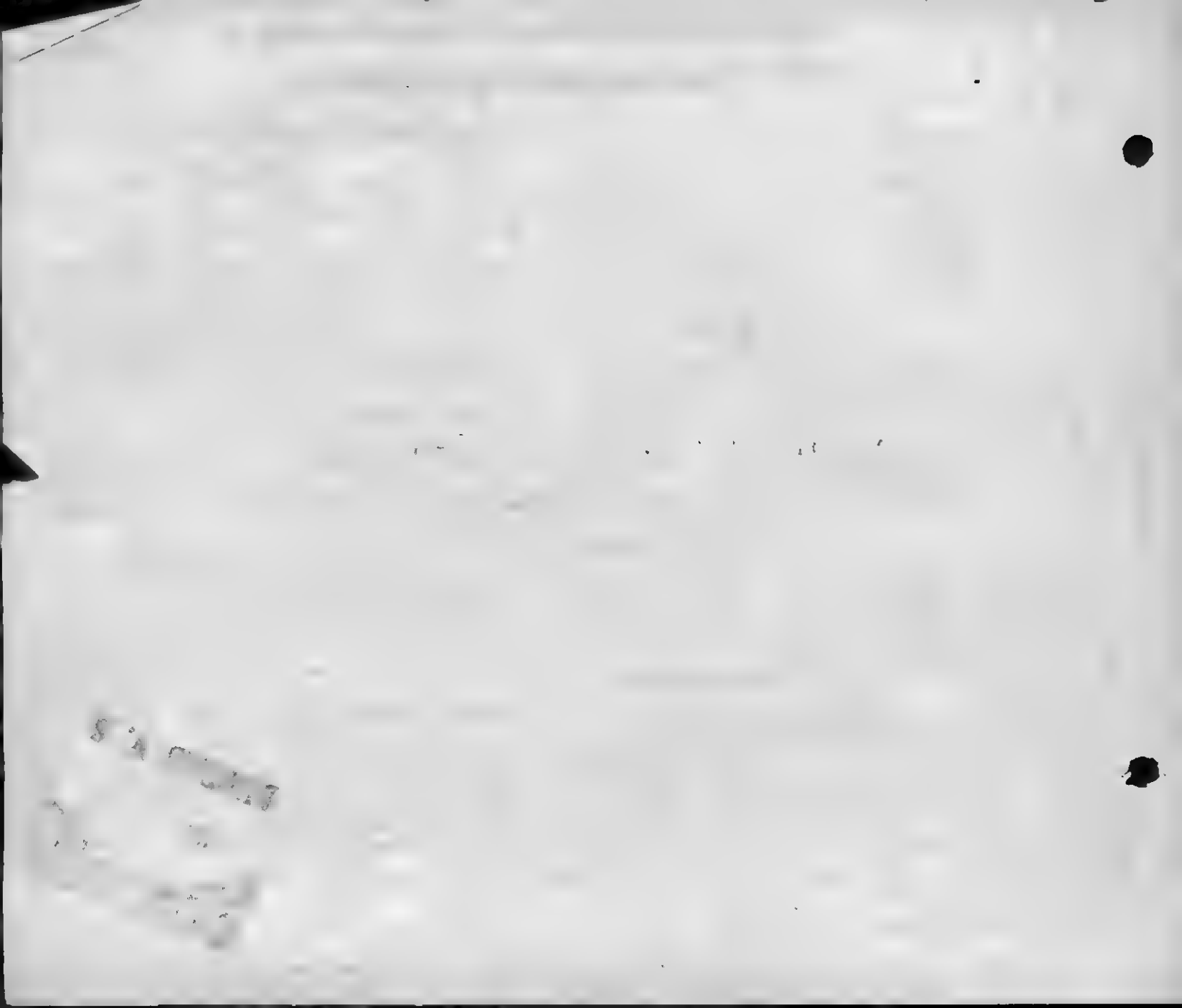
2247

CERTIFICATE OF DEATH

02257

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA Co.</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10. TOWN <u>ANNA POLIS</u>				TOWN <u>ANNA POLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00 35 BUNCHE ST</u>				<u>35 BUNCHE ST</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELIA</u> (Middle) <u>JACKSON</u> (Last)				Month <u>3</u> Day <u>8</u> Year <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>Colored</u>	<u>W</u>	<u>7-29-1885</u>	<u>69</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>DOMESTIC</u>				<u>Md</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Moulden</u>				<u>FANNIE SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>				<u>George Moulden 35 Bunche St</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>442*</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>11 months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Chorea</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While <input type="checkbox"/> Not while <input type="checkbox"/>					
		M. at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>April 18, 1954</u> , to <u>March 8, 1955</u> , that I last saw the deceased alive on <u>March 8, 1955</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard Moulden</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>3/9/55</u>	
M.D. <u>Richard Moulden</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>3-11-55</u>		<u>WILLIAM HILL</u>		<u>ANNA POLIS Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>W. H. HARRIS</u>		<u>ROBERT WASHINGTON</u>		<u>ANNA POLIS MD</u>	
DATE <u>3-10-55</u>							



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2284

CERTIFICATE OF DEATH

02258

Reg. Dist. No. 28

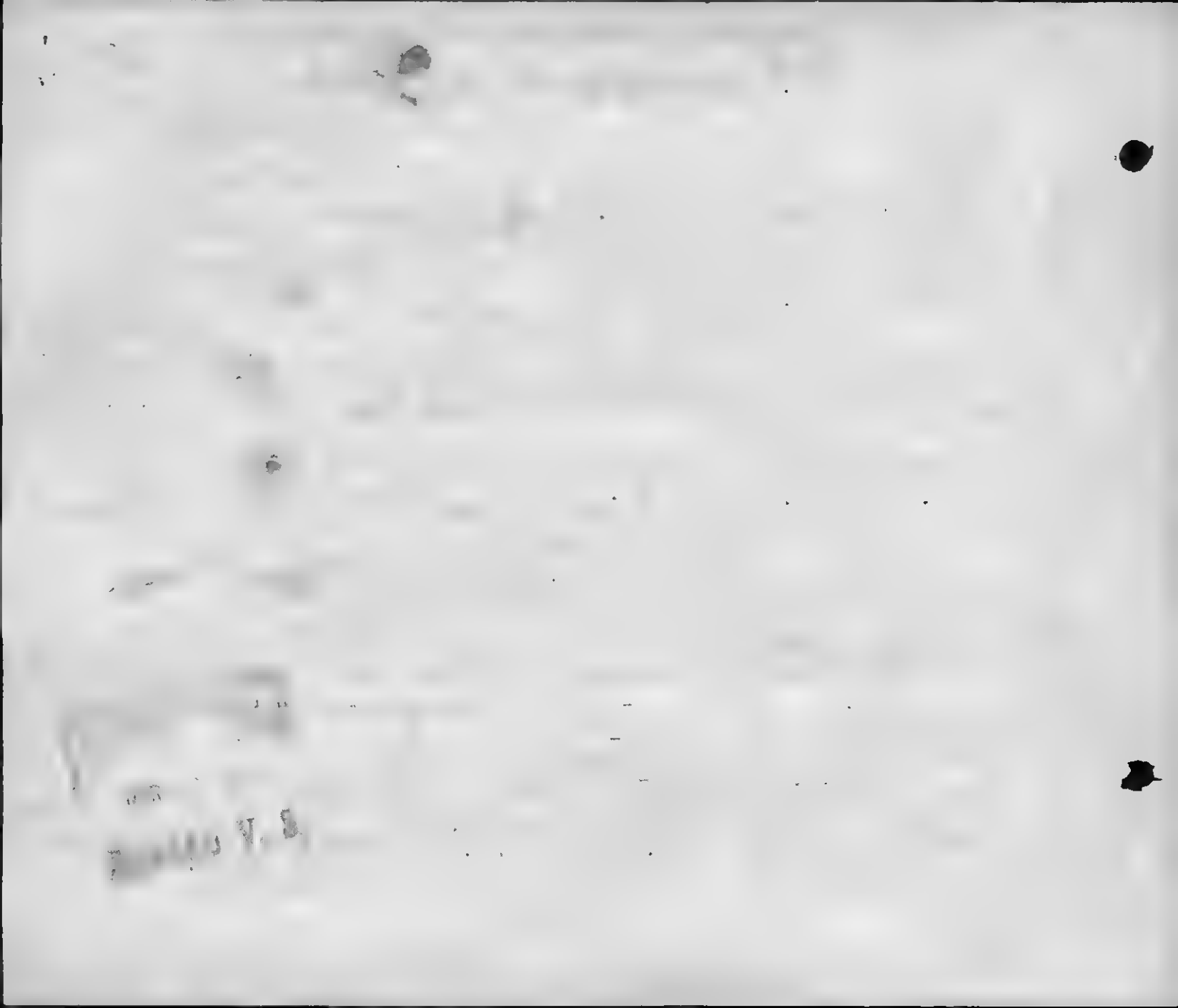
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AnneArundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>2 mos. 16 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		<u>07-10-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>58 Douglas Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Philip</u> (First) <u>Jenkins</u> (Middle) <u></u> (Last)				4. DATE OF DEATH <u>3</u> (Month) <u>16</u> (Day) <u>1955</u> (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1830?</u>	9. AGE last birthday <u>75?</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION							
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> Known to us since <u>12/30/54</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>U</u>		19b. MAJOR FINDINGS OF OPERATION <u></u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>00</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>00</u>			
21d. TIME OF INJURY (Month) (Day) (Year) <u></u> M. <u></u> <u></u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>12/30</u> , 19 <u>54</u> , to <u>3/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/16</u> , 19 <u>55</u> , and that death occurred at <u>1:50a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict, M. D.</u>		DATE SIGNED <u>3/16/55</u>		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE OF BURIAL <u>3/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
24. REC'D BY REGISTRAR <u>3/18/55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>317 High Street Cambridge Md</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2285

02259

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A A</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fredericksville</u>		LENGTH OF STAY (in this place) <u>14 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fredericksville</u>		MD <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Agnes</u> (First) <u>Johnson</u> (Middle) (Last)				4. DATE OF DEATH <u>MAR 19</u> (Month) (Day) (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Aug 25</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Birdsville MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Benj Duwall SR.</u>				14. MOTHER'S MAIDEN NAME <u>Isabell Simms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>4 NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A) <u>Carcinoma of Stomach</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-19-55</u> , 19 <u>3-19-55</u> , to <u>3-19-55</u> , 19 <u>3-19-55</u> , that I last saw the deceased alive on <u>3-18-55</u> , 19 <u>3-18-55</u> , and that death occurred at <u>4:45 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Chris T. Allen</u>				DATE SIGNED <u>3-2-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				NAME OF CEMETERY OR CREMATORY <u>Lady of Sorrows</u>			
24. REC'D BY REGISTRAR <u>March 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Mr. Edward Collier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		LOCATION (City, town, or county) (State) <u>Owensville MD</u>	
DATE				ADDRESS			

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02260

2286

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Anne Arundel CITY OR TOWN X Crownsville HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore CITY OR TOWN Baltimore STREET ADDRESS 723 W. Fayette St. ✓	
3. NAME OF DECEASED (Type or Print) Hattie Jones		4. DATE OF DEATH (Month) March (Day) 24 (Year) 19 55	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Unk.
9. AGE last birthday 67?		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Unk.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT & ADDRESS Hospital Records			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) Hypostatic Pneumonia ANTECEDENT CAUSE(S) DUE TO (B) Cerebrovascular Accident DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertensive & Arteriosclerotic Cardiovascular D's.			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/11/1953 to 3/24/1955, that I last saw the deceased alive on 3/24/1955, and that death occurred at 8:45 PM, from the causes and on the date stated above. SIGNATURE Stanley C. Berger ADDRESS (Street, city, town, state) Crownsville, Md. DATE SIGNED 3/25/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. DATE OF REMOVAL 3/30/55	
25. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem.		26. LOCATION (City, town, or county) (State) Balt. Md.	
27. REC'D BY REGISTRAR 3/25/55		28. REGISTRAR'S SIGNATURE Richard M. Joyce	
29. FUNERAL DIRECTOR'S SIGNATURE W. H. Hester		30. ADDRESS 1918 Snow Hill Rd.	

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10A

U.S. AIR FORCE

RECEIVED
JAN 1954

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

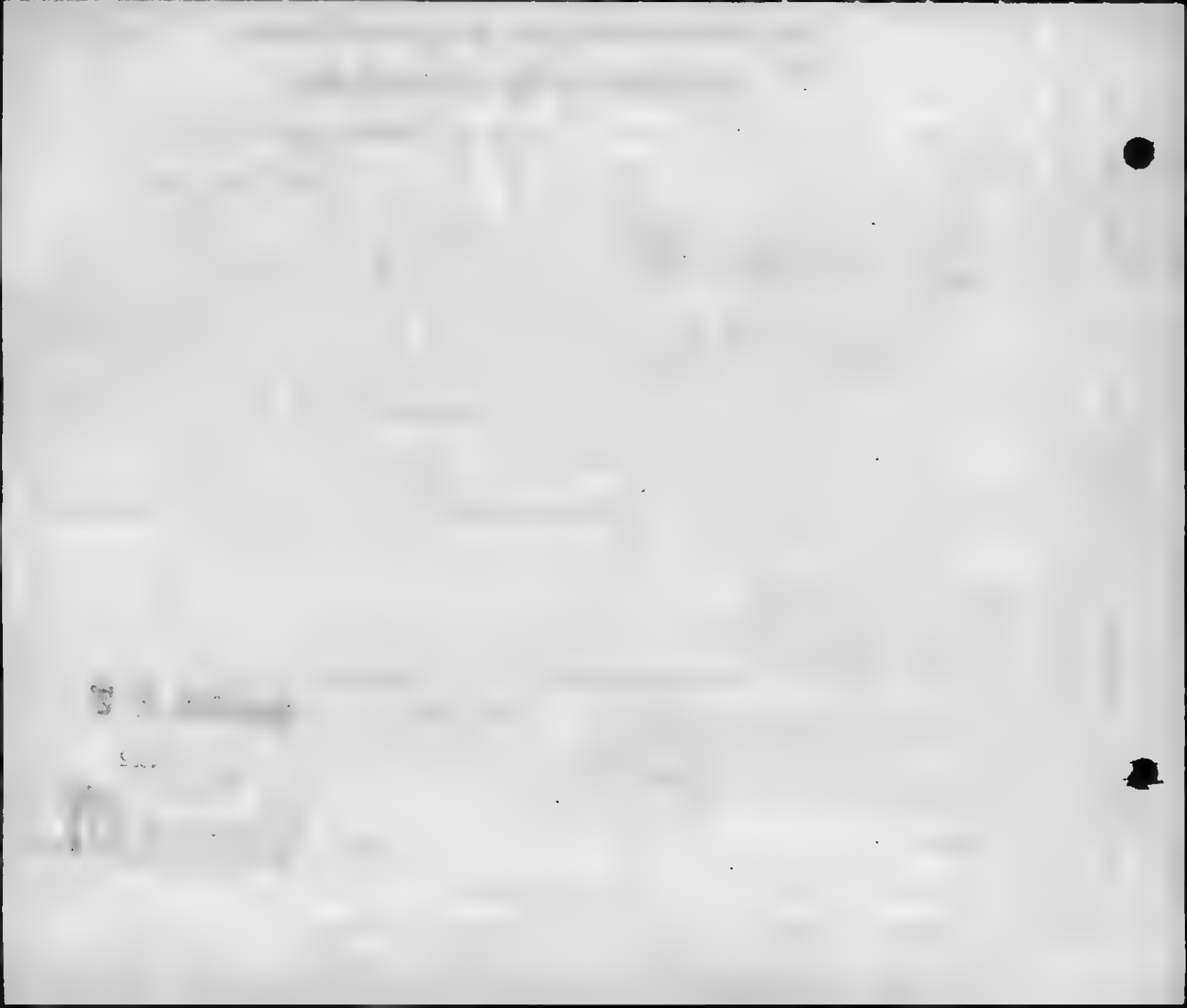
02261

2287

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>BELHAVEN BEACH</u>		3 YRS		Belhaven Beach		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lakewood Road</u>				STREET ADDRESS (if rural give location) <u>Lakewood Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOHN K. F. KESTING</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 14 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>10/26/10</u>		9. AGE last birthday <u>44</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Burners</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Julius Kesting</u>				14. MOTHER'S MAIDEN NAME <u>Mahilda Benner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-1150</u>		17. INFORMANT & ADDRESS <u>Mrs H. Kesting - 104 (same)</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
10. IMMEDIATE CAUSE (A) <u>Carcinoma Lung</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED (While at work) (Not while at work)		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 9/14, 1955 to 3/14, 1955, that I last saw the deceased alive on 3/15, 1955, and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
SIGNATURE <u>J. Brady Smith</u>				ADDRESS (Street, city, town, state) <u>Riviera Beach Md.</u>		DATE SIGNED <u>3/14/55</u>	
				M.D. <u>Riviera Beach Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>		LOCATION (City, town, or county) (State) <u>DORSEY WASHINGTON BLVD. HOWARD CO. MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. D'Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>K. V. SINGLETON</u>		ADDRESS <u>GREEN BLANCKE MD</u>	
DATE <u>March 17, 1955</u>							



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02262

2248

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MD</u>		COUNTY <u>ANN. Co.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS MD.</u>			
TOWN <u>ANNAPOLIS</u>				TOWN <u>ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ANNE ARUNDEL GENERAL</u>				STREET ADDRESS (If rural give location) <u>40 Southgate Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>MARGARET DOWLING King</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 27 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Sept 11, 1875</u>	
9. AGE last birthday <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS DOWLING</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE CHRISTOPHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS <u>WM F. KING ANNAPOLIS MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE (A) <u>injury of Bowel with</u>						<u>87 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastasis to liver.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/27/1955</u> , to <u>3/27/1955</u> , that I last saw the deceased alive on <u>3/27/1955</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above							
SIGNATURE <u>John M. Taylor</u>				DATE SIGNED <u>3/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>BAKOWN MEMORIAL</u>		LOCATION (City, town, or county) (State) <u>MILLERSVILLE MD.</u>	
24. REC'D BY REGISTRAR <u>John M. Taylor</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>ANNAPOLIS MD.</u>	
DATE <u>March 29, 1955</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2249

CERTIFICATE OF DEATH

02263

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
10 TOWN <u>ANNAPOLIS</u>				TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
03 <u>EMERGENCY HOSP.</u>				<u>3322 CHARLES HANE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
(First) <u>JULIUS</u> (Middle) <u>A.</u> (Last) <u>KLAWANS</u>				(Month) <u>3</u> (Day) <u>18</u> (Year) <u>1955</u>			
6. SEX	7. COLOR OR RACE	8. SINGLE, MARRIED, WIDOWED, DIVORCED	9. DATE OF BIRTH	10. AGE last birthday		11. IF UNDER 1 YEAR	
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>8-9-1896</u>	<u>58</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if temporary)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>MERCHANT</u>		<u>MENS WEAR</u>		<u>BALTIMORE, MD</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>DAVID</u>				<u>LENA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>MOHAYE KLAWANS - SAME</u>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
4201 IMMEDIATE CAUSE (A) <u>Myocardial Infarction, anterior</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u>			
ANTECEDENT CAUSE(S) <u>DOE TO</u> <u>Septal</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. <u>DOE TO</u> <u>Congestive Failure</u>				1 day			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/14</u> , 19 <u>55</u> , to <u>3/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/18</u> , 19 <u>55</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>			
DATE THEREOF <u>3-20-55</u>				DATE SIGNED <u>3/18/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>Beth T. Philon</u>		<u>Balto</u>		<u>Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>March 22, 1955</u>		<u>Thos. J. Lueck</u>		<u>Jack Lewis</u>		<u>2100 Eastern Pl</u>	

3. K. NORMAN

1922-1923

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02264

2288

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>GLEN BURNIE</u>		<u>11 YEARS</u>		TOWN <u>GLEN BURNIE</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 THIRD AVE. S.W.</u>				STREET ADDRESS (If rural give location) <u>201 THIRD AVE. S.W.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Martha</u> (Middle) <u>-</u> (Last) <u>Kriewald</u>				(Month) <u>3</u> (Day) <u>3</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>OCT. 19, 1885</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK DEKORABER</u>				14. MOTHER'S MAIDEN NAME <u>BERTHA LUDTKE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT & ADDRESS <u>MRS. ALMA TELMEIER</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4201 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis & Hypertension</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 19 34</u> to <u>March 19 55</u> , that I last saw the deceased alive on <u>2-26</u> , 19 <u>53</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. McDonald</u>		M.D. <u>Glen Burnie Md</u>		DATE SIGNED <u>3-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>DEKORABER PRIVATE</u>		LOCATION (City, town, or county) <u>FOOT SEVERN, MD</u>	
24. REC'D BY REGISTRAR <u>March 5, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. Dealba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>DeFuneral</u>		ADDRESS <u>Glen Burnie, Md</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2250 MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

02265

Reg. Dist. No. 142

1. PLACE OF DEATH - COUNTY <u>M.A.C.O.</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD.</u> COUNTY <u>WA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 TOWN Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>158.2 TOWN BETHESDA, MD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>BRADLEY BLVD RING RD.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Albert</u> (Middle) <u>EDWARD</u> (Last) <u>Landvoigt</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>JAN 11, 1892</u>	9. AGE last birthday <u>63</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MORRIS BANKING (PRES)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>EDWARD LANDVOIGT</u>		14. MOTHER'S MAIDEN NAME <u>VERGIA ANN WHEGLOCK</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.O.I.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

Seven

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL OR CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

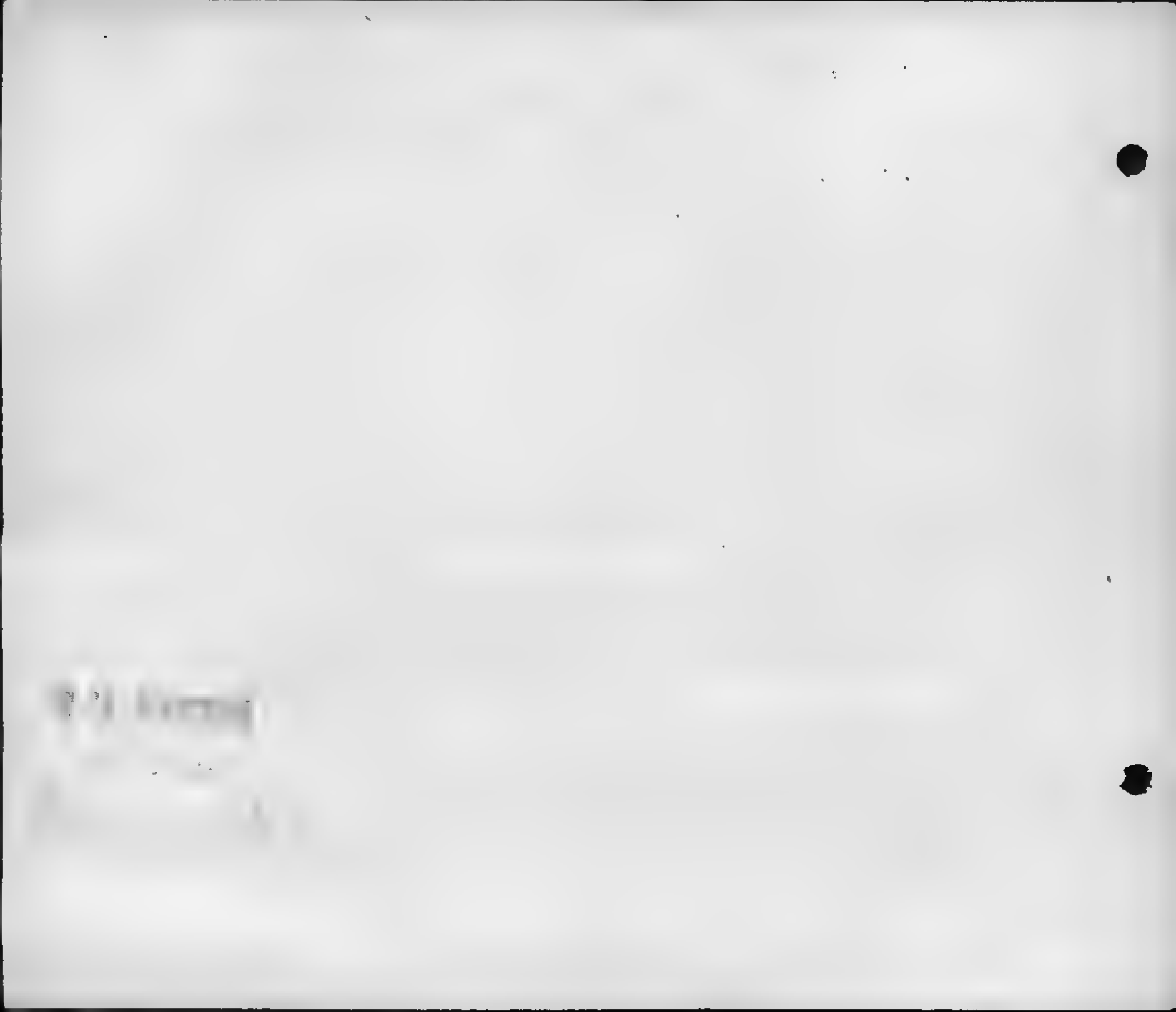
DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar. 28, 55Carrie J. CampbellWm. J. French300 4th St. N.E. WASH. D.C.



CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Port Republic</i> LENGTH OF STAY (in this place) <i>30 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN _____ STREET ADDRESS (If rural, give location) _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Green Harbor</i>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Edmund Lemieux</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>March 4 1955</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>9/12/93</i>
9. AGE last birthday <i>61</i> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Preparing light bulbs</i>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <i>Maryland, U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME _____		14. MOTHER'S MAIDEN NAME _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Yes 1907</i>		16. SOCIAL SECURITY NO. <i>2-12-26-0841</i>	
17. INFORMANT AND ADDRESS <i>Records found in his home.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>42-1</i> Immediate cause (a) <i>Is an aneurysm of the aorta</i> Antecedent cause(s) (b) _____ Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		<i>2 weeks</i>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <i>March 11, 1955</i>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. INTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) (Min.) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

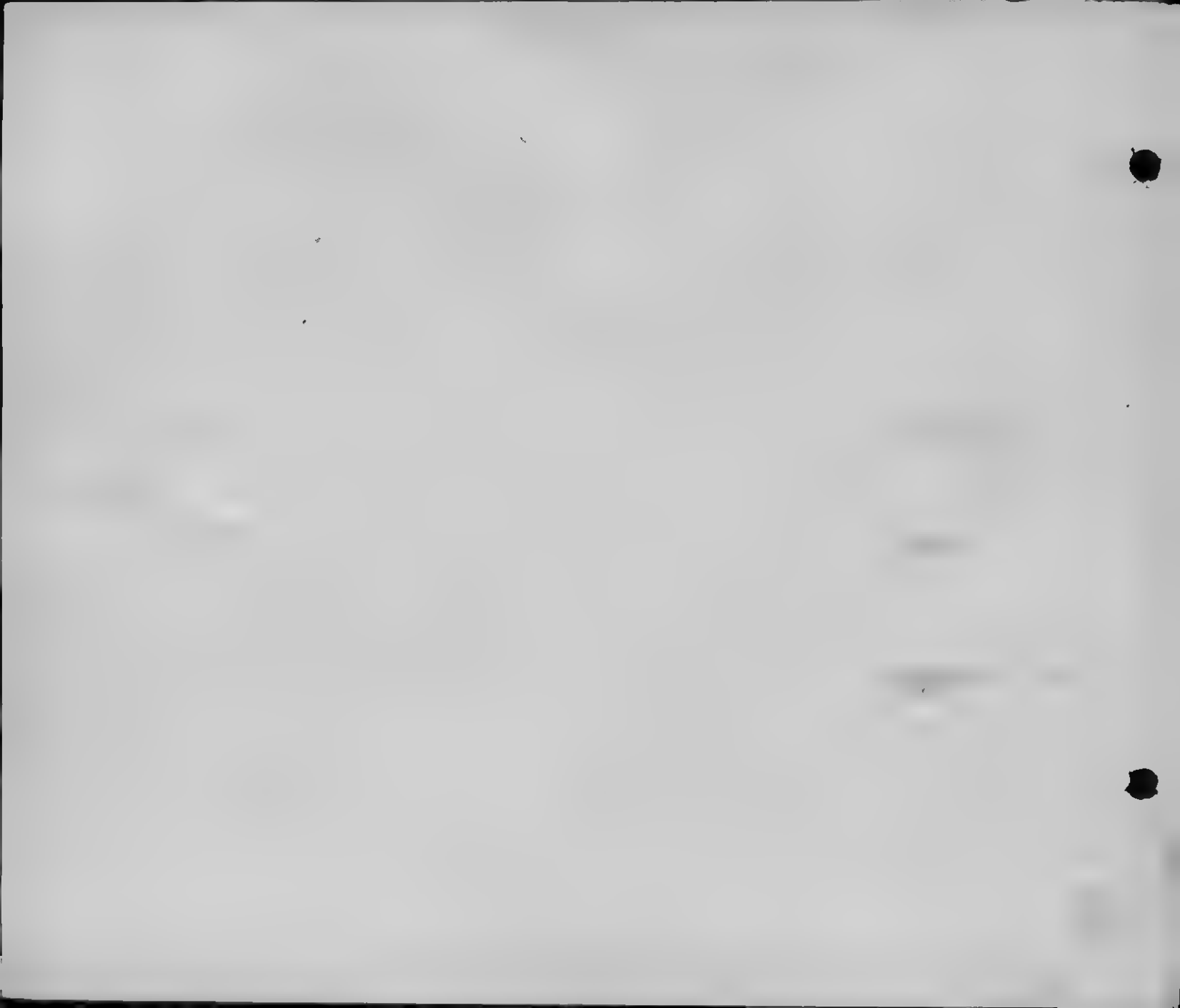
SIGNATURE *Edward P. ...* (Degree optional) ADDRESS *Interstate Medical Center, Glenview, Ill.* DATE SIGNED *3/9/55*

DATE OF INTERMENT (Month) (Day) (Year)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>BURIAL</i>	<i>MARCH 11, 1955</i>	<i>BALTIMORE NATIONAL</i>	<i>BALTIMORE</i>	<i>MARYLAND</i>

23. FILED BY LOCAL REGISTRAR'S SIGNATURE *W. H. ...* ADDRESS *6009 HARFORD RD.*

MARGIN RESERVED FOR BINING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2251

CERTIFICATE OF DEATH

02267

Reg. Dist. No. 21

Item 7. Film 179 3-23-55 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>AA.</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Annapolis</i>	<i>4 mos.</i>	TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Homewood Convalescing Home</i>		STREET ADDRESS (If rural give location)	<i>1312 West St. Annapolis Md.</i>
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>JAMES C LEWIS</i>		<i>March 6 1955</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Jan. 8, 1875</i>
		9. AGE last birthday <i>80</i> yrs.	IF UNDER 1 YEAR <i>1</i> Months <i>25</i> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Care Taker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>London Park Century Frederick Co., Md.</i>	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME <i>Alfred Lewis</i>		14. MOTHER'S MAIDEN NAME <i>Annabelle Wenter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-07-7266</i>	
		17. INFORMANT & ADDRESS <i>Mildred L. Conley 2237 W. Balto. St.</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE (A) <i>Arteriosclerotic Cardio Vascular</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>chronic with decompensation</i>			<i>Yrs.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3/4</i> 1955, to <i>3/6</i> 1955, that I last saw the deceased alive on <i>3/4</i> 1955, and that death occurred at <i>9 P.</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Mamie L. Loman</i>		ADDRESS (Street, city, town, state) <i>Annapolis, Md.</i>	
DATE <i>3/14/55</i>		DATE SIGNED <i>3/8/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>3-10-55</i>	NAME OF CEMETERY OR CREMATORY <i>Kempstown</i>	LOCATION (City, town, or county) <i>Frederick Co. Md.</i>
24. REC'D BY REGISTRAR <i>3/14/55</i>	REGISTRAR'S SIGNATURE <i>Wm. J. Funch</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick Co. Md.</i>	ADDRESS <i>1913 W. Balto. St.</i>

BUREAU V. S.

MAR 10 1975



MARYLAND

2290

02268

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH - COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - COUNTY <u>Anne Arundel</u> STATE <u>Md.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easthigh Heights</u> OR <u>Town</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easthigh Heights</u> OR <u>Town</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 449 Severna Park Md.</u>		STREET ADDRESS <u>Box 449 Severna Park Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>Elsie Marie</u> (First) <u>1-18</u> (Middle) (Last)		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 1-1898</u> <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>Frederick Bunk</u>		14. MOTHER'S MAIDEN NAME <u>ELSA Fricke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
		17. INFORMANT AND ADDRESS <u>George Listman (Son)</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>MYOCARDIAL INFARCTION (M.I.)</u>		
(b) Antecedent cause(s) <u>Hypertensive arteriosclerosis</u>		<u>Year</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Cardio-vascular disease</u>		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>have never attended the deceased</u> , 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>10 P. M.</u> , from the causes and on the date stated above.	
SIGNATURE <u>Robert R. Hakim M.D.</u> (Office or title)	ADDRESS <u>Severna Park Md</u> DATE SIGNED <u>12 March</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE <u>March 16/55</u> NAME OF CEMETERY OR CREMATORY <u>St. John's Lutheran Church</u> LOCATION (City, town, or county) <u>Howard Co. Md.</u> (State)
DATE REC'D BY LOCAL REG <u>March 14, 1955</u>	REGISTRAR'S SIGNATURE <u>L. J. DeArbo</u> 24. FUNERAL DIRECTOR <u>R. V. Singleton</u> ADDRESS <u>San Bruno, Md.</u>

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1955

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02269

2291

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>				STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>2801 Raynor Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles H. Lowery</u>				4. DATE OF DEATH <u>3 1 19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>1877?</u>	
9. AGE last birthday <u>78?</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		11. IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>— — — —</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>450.0</u> IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>				<u>Known to us since 11/10/54</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>— — — —</u>		19b. MAJOR FINDINGS OF OPERATION <u>— — — —</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>— — — —</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>— — — —</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>— — — —</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>— — — —</u>			
22. I hereby certify that I attended the deceased from <u>11/10</u> , 19 <u>54</u> , to <u>3/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/1</u> , 19 <u>55</u> , and that death occurred at <u>3:45 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/1/55</u>	
23. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		DATE THEREOF <u>3/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Baltimore City</u>	
24. REC'D BY REGISTRAR <u>Mar. 7, 1955</u>		REGISTRAR'S SIGNATURE <u>Katherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Kate R. Williams</u>		ADDRESS <u>322 N. Schroeder St.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.



2252

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>	STATE <i>Md.</i> COUNTY <i>aa</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>
TOWN <i>Annapolis Md.</i>	LENGTH OF STAY (In this place)	STREET ADDRESS (If rural give location)	ADDRESS <i>132 Charles</i>
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
<i>James Mitchell Magruder</i>		OF DEATH: <i>3-11-1955</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>8-4-1865</i>
9. AGE last birthday: <i>89</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <i>Minister</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Episcopal</i>	
11. BIRTHPLACE (State or foreign country): <i>Mississippi</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>William Howard Magruder</i>		14. MOTHER'S MAIDEN NAME: <i>Ann E. Mitchell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT & ADDRESS: <i>Margaret M. Magruder</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
452X IMMEDIATE CAUSE		<i>4 wks.</i>	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<i>4 wks.</i>	
(A) <i>Gangrene (dry) right foot</i>			
DUE TO			
(B) <i>Thrombosis of aneurysm of rt.</i>			
DUE TO			
<i>popliteal artery + atherosclerosis, generalized</i>		<i>yr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>3/11/1955</i> , 1950, to <i>3/11/1955</i> , that I last saw the deceased alive on <i>3/10/1955</i> , and that death occurred at <i>3:47 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Frank M. Shipley</i>		DATE SIGNED <i>3/11/55</i>	
ADDRESS		M. D. <i>Annapolis</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <i>3-11-55</i>	
NAME OF CEMETERY OR CREMATORY <i>St. Edward's Cem.</i>		LOCATION (City, town, or county) <i>Annapolis Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>March 11, 1955</i>		24. FUNERAL DIRECTOR <i>John M. Taylor & Sons</i> ADDRESS <i>Annapolis Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1901

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2292

CERTIFICATE OF DEATH

02271

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Illinois ^{MD}		COUNTY Kankakee	
CITY OR TOWN Fort George G. Meade		LENGTH OF STAY (in this place) 2 months		CITY OR TOWN Buckingham			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Army Hospital				STREET ADDRESS (If rural give location) -			
3. NAME OF DECEASED (Type or Print) Connie Ann McClintock				4. DATE OF DEATH March 13 1955			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single		8. DATE OF BIRTH 13 March 1955	
9. AGE last birthday 3 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Edward McClintock				14. MOTHER'S MAIDEN NAME Martha Virginia Pfutzenrueter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. XXXX		17. INFORMANT & ADDRESS Father: 89th AAA, Ft GG Meade, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 hrs 10 min	
IMMEDIATE CAUSE (A) Prematurity - 20 weeks gestation							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1845 13 Mar 1955 to 2155 13 Mar 1955 , that I last saw the deceased alive on 13 Mar 1955 and that death occurred at 2155 M, from the causes and on the date stated above.							
SIGNATURE Fredrick S. Eadie				ADDRESS (Street, city, town, state) Fort George G. Meade, Md.			
DATE SIGNED 13 Mar 55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal - remains granted to remove remains to Second Army Med Lab, FGGM, Md.							
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Arthur J. Gombosh		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 14 Mar 55		ARTHUR J. GOMBOSH, CAPT., MSC		none			

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BUREAU V. S.

MAR 16 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2293

CERTIFICATE OF DEATH

02272

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Caroline	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Crownsville		LENGTH OF STAY (in this place) 2yrs. 2mos. 24 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Preston		C X - 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital				STREET ADDRESS (If rural give location) Rt. #2, Box 87B			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Wilbert		(Middle) Monroe		(Last) Murray		3 7 19 55	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 10/23/01	9. AGE last birthday 53 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William H. Murray				14. MOTHER'S MAIDEN NAME Clara E. Hubbard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS Hospital Records			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Terminal bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSE(S) DUE TO (B) General Paresis						Known to us since 12/11/52	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work		21e. INJURY OCCURRED While at work Not white at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/11, 19 52, to 3/7, 19 55, that I last saw the deceased alive on 3/7, 19 55, and that death occurred at 4:30p.m. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
L. Benedict M.D. (L. Benedict)				Crownsville, Md.		3/8/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		3/12/55		Jonestown Cemetery Jonestown		Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 3 - 12 - 55		1 M Soze		J. J. Thompson & Son - Federalburg, Md.			

STANDARD

NO. 10 1935

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

02273

2253

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>aa</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>10</u>		STREET ADDRESS (If rural, give location) <u>903 Jackson</u>	
3. NAME OF DECEASED (Type or Print) <u>Carl</u> (First) <u>Wayne</u> (Middle) <u>Neumiller</u> (Last)		4. DATE OF DEATH (Month) <u>3-</u> (Day) <u>29-</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-17-53</u>
9. AGE last birthday <u>2</u> yrs.		10. AGE last birthday If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer L. Neumiller</u>		14. MOTHER'S MAIDEN NAME <u>Ruby L. Sears</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Elmer L. Neumiller</u> (2)		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>716.0</u> Immediate cause (a) <u>Apoplexy</u> Antecedent cause(s) (b) <u>3rd degree burns - 100% body surface</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Sudden</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3</u> <u>29</u> <u>55</u> <u>A</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>House fire</u>		(CITY OR TOWN) <u>Annapolis</u> (COUNTY) <u>AAco</u> (STATE) <u>Md</u>	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Elmer L. Neumiller</u>		DATE SIGNED <u>3/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>3-31-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>	
DATE REC'D BY LOCAL REG. <u>March 30, 1955</u>		24. FUNERAL DIRECTOR <u>John W. Taylor Sons Annapolis Md.</u>	

BUREAU V. S.

APR 1 1954

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2294

CERTIFICATE OF DEATH

02274

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Tracy's Landing</i>				TOWN <i>Tracy's Landing</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>Mc. Kendree Rd</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Maggie</i> (Middle) <i>Virginia</i> (Last) <i>Ewens</i>				(Month) <i>Mar.</i> (Day) <i>18</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>colored</i>	<i>married</i>	<i>Oct. 25, 1884</i>	<i>76</i> yrs.	Months <i>11</i>	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>House wife</i>				<i>U. S. A.</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John Brown</i>				<i>Emily Carroll</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Elizabeth Easton</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <i>coronary artery disease with</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>chronic myocardial failure</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov.</i> , 19 <i>53</i> , to <i>March 18</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>March 18</i> , 19 <i>55</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Emily H. Wilson</i>				ADDRESS (Street, city, town, state) <i>Lothian, Md.</i>		DATE SIGNED <i>3-14-55</i>	
				M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Mar. 22, 1955</i>		<i>Adams</i>		<i>Lothian, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>3-22-55</i>		<i>Elmer W. H. Wilson</i>		<i>J. B. Johnson</i>		<i>Greenpoint, Md.</i>	

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02275

2295 MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

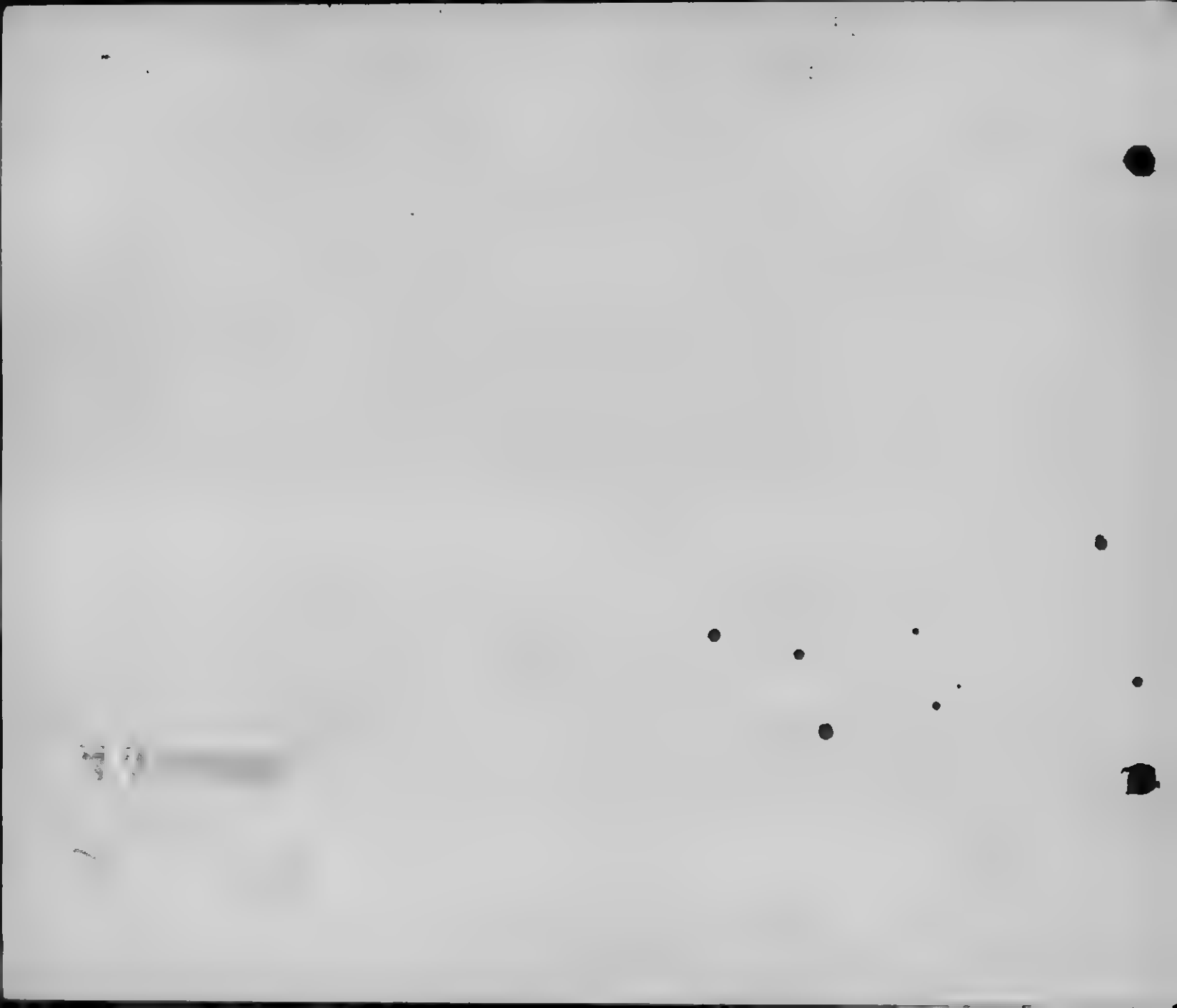
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH - COUNTY <u>Harwood</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
TOWN <u>Pasadena</u>		TOWN <u>Pasadena</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 87 - Route 1</u>		STREET ADDRESS (If rural, give location) <u>Box 87 - Route 1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Harry</u> (Middle) <u>Albert</u> (Last) <u>Pallerson</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH
9. AGE last birthday <u>79</u> yrs.		10. UNDER 1 year Months	11. UNDER 24 hrs. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry C. Pallerson</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>210-10-7104</u>	
17. INFORMANT AND ADDRESS <u>Mr. L. A. Patterson (Son)</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>Myocardial Infarction</u>		<u>Sudden</u>	
Antecedent cause(s) <u>General Arterio Sclerosis</u>		<u>?</u>	
Disease or condition, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. INTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Howard A. Patterson</u> (Degree or title) <u>Medical Examiner - Glen Burnie, Md.</u>		DATE SIGNED <u>3/3/55</u>	
23a. CREMATION (If yes, specify)	DATE THEREOF <u>3-7-55</u>	NAME OF CEMETERY OR CREMATORY <u>Howard Park</u>	LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG <u>March 10, 1955</u>	REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>	24. FUNERAL DIRECTOR <u>Howard A. Patterson</u> ADDRESS <u>4107 W. ...</u>	

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2296

CERTIFICATE OF DEATH

02276

Reg. Dist. No. *8*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE ARUNDEL		MARYLAND		STATE MARYLAND		COUNTY ANNE ARUNDEL	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
✓ TOWN ODENTON				TOWN ODENTON		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (First) (Middle) (Last) MARION I POORE				4. DATE OF DEATH (Month) (Day) (Year) MARCH 31, 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH January 7, 1876		9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Campbell				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. James S. Poore- Son- same as # 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
4-000 IMMEDIATE CAUSE (A) Anteriosclerotic Heart Disease						16 years	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct 1946</i> , to <i>Mar 31</i> , 1955 , that I last saw the deceased alive on <i>Mar 29</i> , 1955 , and that death occurred at <i>6 P.</i> M. from the causes and on the date stated above.							
SIGNATURE <i>Edward G. Bennett</i>				ADDRESS (Street, city, town, state) <i>Cambria 17d</i>		DATE SIGNED <i>3-31-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 4, 55		NAME OF CEMETERY OR CREMATORY Our Lady of the Fields		LOCATION (City, town, or county) (State) Millersville, A.A. Maryland	
24. REC'D BY REGISTRAR DATE <i>4-3-55</i>		REGISTRAR'S SIGNATURE <i>JKM Taylor</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Ben L. Hopping</i> HOPPING FUNERAL HOME ANNAPOLIS, MD.			

U.S. AIR FORCE

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02277

2297

CERTIFICATE OF DEATH

Reg. Dist. No. ... 22 ...

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	
X TOWN <u>ODENTON RURAL</u>		<u>36 YRS</u>		TOWN <u>ODENTON (RURAL)</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WAUGH CHAPEL ROAD</u>				STREET ADDRESS (If rural give location) <u>WAUGH CHAPEL ROAD</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WILLIAM</u> (Middle) <u>PULLMAN</u> (Last)				(Month) <u>MARCH</u> (Day) <u>15</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>SEPT. 6 1876</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FARMING</u>		<u>OWN FARM</u>		<u>RUSSIA</u>		<u>RUSSIA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>FREDERICK PULLMAN</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		18. INTERVAL BETWEEN ONSET AND DEATH	
<u>NO</u>		<u>NONE</u>		<u>HELENA K. PULLMAN</u>		<u>WAUGH CHAPEL ROAD</u> <u>CAMPBELL'S</u>	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				20. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Atherosclerosis</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 15, 1955</u> to <u>March 15, 1955</u> , that I last saw the deceased alive on <u>March 13, 1955</u> , and that death occurred at <u>March 15, 1955</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph L. Lippert</u> M.D.				ADDRESS (Street, city, town, state) <u>Odenton, Maryland</u>			
DATE SIGNED <u>March 17, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/18/55</u>		<u>WAUGH CHAPEL</u>		<u>WAUGH CHAPEL ANN</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>March 19, 1955</u>		<u>Clara Shup</u>		<u>W. Singleton</u>		<u>Blountsville, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 415C 1-55 10M

BURKHOFF & S

APR 12 1964
FBI

MARYLAND

2298

02278

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EARLEIGH Heights</u> LENGTH OF STAY (in this place) <u>14 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EARLEIGH Heights</u> MD	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gov. Ritchie Hwy.</u>		STREET ADDRESS <u>Gov. Ritchie Hwy.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JAMES Stewart Rennie</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 30 1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>MAY 18, 1890</u>
9. AGE last birthday <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES Rennie</u>		14. MOTHER'S MAIDEN NAME <u>ISABELLA Redman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Yes W.W.I.</u>		16. SOCIAL SECURITY No. <u>213-16-5631</u>	
17. INFORMANT AND ADDRESS <u>WIFE</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1		Heart Failure - <u>myocardial inf</u>		7-8 yrs	
Immediate cause (a)...		Arteriosclerotic C.V. Disease			
Antecedent cause(s) (b)...		Probable Coronary Insufficiency			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)...					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
OF INJURY		m.			

22. I hereby certify that I attended the deceased from patient was not seen alive by me., 1955, to seen alive by me., 1955, that I last saw the deceased

alive on April 2, 1955, 1955, and that death occurred at 0900 m., from the causes and on the date stated above.

SIGNATURE <u>Robert G. John</u>		ADDRESS <u>Severna Park Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>April 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Maryland</u>			
DATE REC'D BY LOCAL REG. <u>April 2, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. Balba</u>		24. FUNERAL DIRECTOR <u>L. J. Balba</u>	
				ADDRESS <u>Gov. Ritchie Hwy.</u>	

MARGIN RESERVED FOR BINDING

12-11-40

12-11-40

12-11-40

2299

MARYLAND STATE DEPARTMENT OF HEALTH

02279

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <i>Elton Burns, D.D. Co. MARYLAND</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Same</i> COUNTY <i>-</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Elton Burns</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Same</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>308 Central Ave. N.W.</i>		STREET ADDRESS (If rural, give location) <i>Same</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>Eliza</i> (Middle) <i>M.</i> (Last) <i>Rogan</i>		4. DATE OF DEATH (Month) <i>March</i> (Day) <i>8</i> (Year) <i>1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>6/15/1867</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE last birthday <i>87</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Mc Fadden</i>		14. MOTHER'S MAIDEN NAME <i>Eliza Mc Fadden</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Dorothy Dunbar (Daughter)</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <i>Carcinoma of the Vagina & of the Uterus</i>			<i>8 months</i>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Carcinoma of the Breast</i>			<i>10 years</i>
(c) <i>None</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>None</i>			
19a. DATE OF OPERATION <i>1945</i>		19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of the Breast</i>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> Thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> . accident <input type="checkbox"/> . suicide <input type="checkbox"/> . homicide <input type="checkbox"/> . undetermined <input type="checkbox"/> .			
SIGNATURE <i>James S. Billings Jr. M.D.</i>		DATE SIGNED <i>March 3, 1955</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>3/10/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		LOCATION (City, town, or county) (State) <i>Woodlawn Maryland</i>	
DATE REC'D BY LOCAL REG. <i>3/9/55</i>		REGISTRAR'S SIGNATURE <i>H.W. Whitehead</i>	
24. FUNERAL DIRECTOR <i>H.M. Cook, Inc.</i>		ADDRESS <i>1217 St. Paul St.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2300

CERTIFICATE OF DEATH

02280

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>				STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gaithersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Wallfield Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>John Thomas Ross</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 13 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>1860?</u>	9. AGE last birthday <u>85?</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY -- --		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420- IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerotic Heart Disease</u>						Known to us since	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>						<u>1/19/55</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						" "	
19a. DATE OF OPERATION <u>1/19/55</u>		19b. MAJOR FINDINGS OF OPERATION -- -- --				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work Not white at work		21e. INJURY OCCURRED While at work Not white at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/19</u> , 19 <u>55</u> , to <u>3/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>55</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Hildegard Heard Reisman</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>3/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Brook Grove</u>		LOCATION (City, town, or county) (State) <u>Laytonville, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>3-14-55</u>		REGISTRAR'S SIGNATURE <u>K M Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED A. S.

1911

1911

2254

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN Annapolis		13 Days		TOWN Severn (Rural) X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
Bonnie Lou Royal				March 6, 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
F	W	Single	February 21, 1955		13		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Royal				Shirley Mae Wheeler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		John Royal, Severn, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
451X IMMEDIATE CAUSE (A)				Spina BiFida			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				15 days			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3621, 19 55, to 19 55, that I last saw the deceased alive on Mar 5, 19 55, and that death occurred at 10:54 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Glen Burnie, Md.				Glen Burnie, Md.		3-6-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3/8/55		Glen Haven		Glen Burnie, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE March 8, 1955		Hopping and Kirkley, Glen Burnie, Md.					

2025182414

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

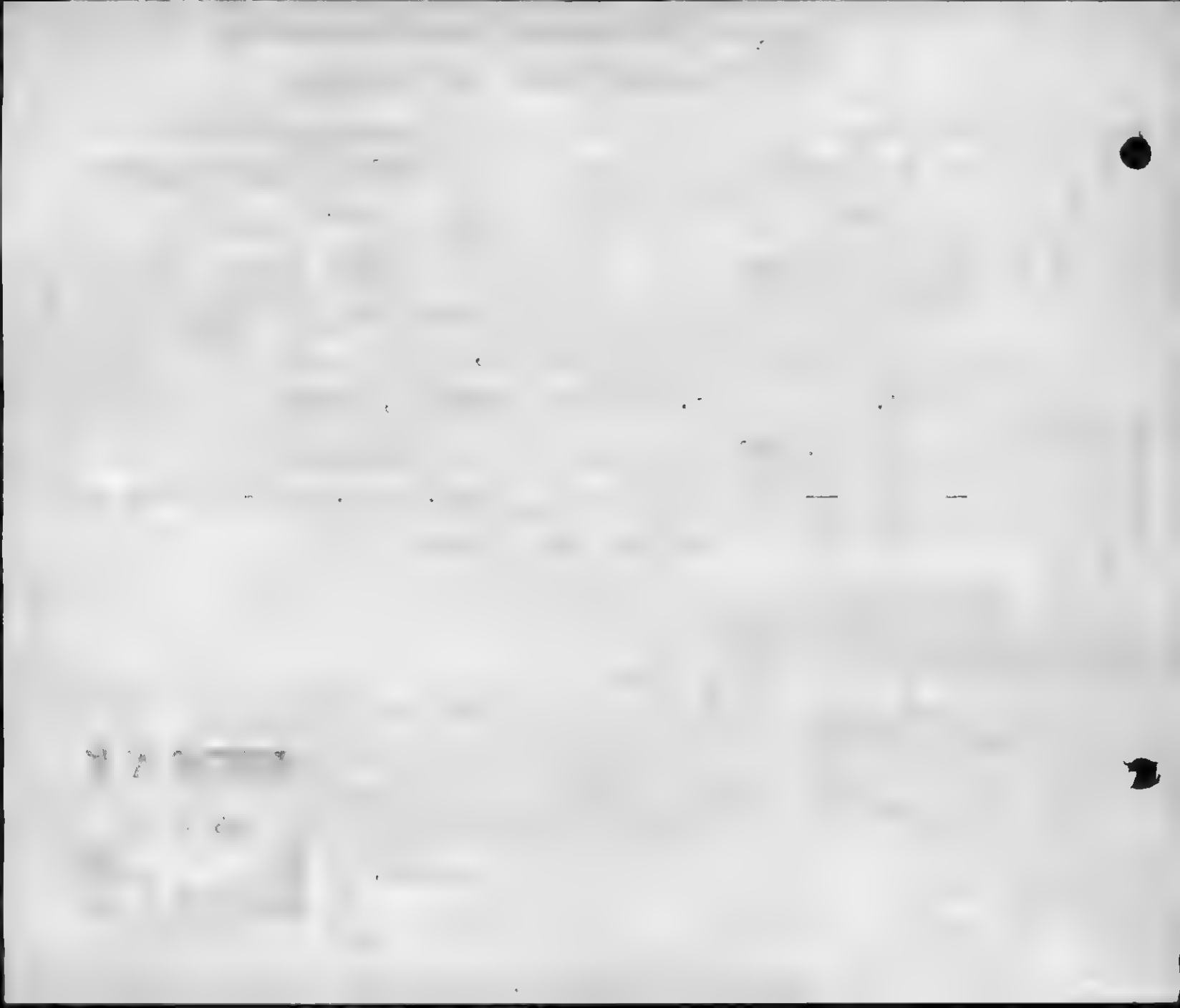
2255 item 14, filed 1804-11-55 et

02282

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Weems Creek				STREET ADDRESS (If rural give location) Weems Creek			
3. NAME OF DECEASED (Type or Print) JOHN W SEWELL				4. DATE OF DEATH (Month) (Day) (Year) MARCH 31 19 55			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH August 13, 1874		9. AGE last birthday 80 yrs.	10. IF UNDER 1 YEAR (Months) (Days) 19 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Gov. Employee		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Sewell				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Rose E. Sewell-Wife- same as # 2			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) bilateral pulmonary tuberculosis						??	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/29/54, 19, to 3/31/55, 19, that I last saw the deceased alive on 3/30/55, 19, and that death occurred at 10:40PM, from the causes and on the date stated above.							
SIGNATURE <i>S. Bornick</i>		M.D. Annapolis, Md.		DATE SIGNED 4/1/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF April 4, 55		NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. REC'D BY REGISTRAR April 4, 1955		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS HOPPING FUNERAL HOME ANNAPOLIS, MD			



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02283

2256 CERTIFICATE OF DEATH

Item 9, Film 180 4-20-55 et

Reg. Dist. No. ... 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA Co</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA Co</u>	
CITY (if outside corporate limits, write RURAL OR and give nearest town) <u>ANNA POLIS</u>		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town) <u>ANNA POLIS</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 CALVERT ST</u>				STREET ADDRESS (if rural give location) <u>90 CALVERT ST</u>		1	
3. NAME OF DECEASED (Type or Print) <u>ESTELLA BATSON STANTON</u>				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>9th</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-23-1905</u>	9. AGE last birthday <u>49 yrs.</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER STERENS</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR BATSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS <u>ELEANOR BATSON 90 CALVERT ST</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				442x IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Hypertension</u>			
2. ANTECEDENT CAUSE(S) DUE TO				<u>Cardio-renal disease</u>			
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				(B) <u>Chronic</u>			
4. STATING UNDERLYING CAUSE LAST. DUE TO				(C) <u>Chronic</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> et/work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 1st</u> , 19 <u>55</u> , to <u>Nov 9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 9</u> , 19 <u>55</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above							
SIGNATURE <u>William Reese II</u>		M.D. <u>William Reese II</u>		ADDRESS (Street, city, town, state) <u>108 Washington Ter, ST ANNAPOLIS, MD</u>		DATE SIGNED <u>3/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Annes Hill</u>		LOCATION (City, town, or county) <u>ANNAPOLIS, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. W. Hedrick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II</u>		ADDRESS <u>108 Washington Ter, ST ANNAPOLIS, MD</u>	
DATE <u>2-10-55</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED
F. A. C. 100

1968

100-100000

2257 CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 11, File #179 3-18-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY A.A. Co		MARYLAND		STATE Md.		COUNTY A.A. Co.	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1316 Bay Ridge Ave.				STREET ADDRESS (If rural give location) 1316 Bay Ridge Ave.			
3. NAME OF DECEASED (Type or Print) JOHN E. STOKES SR.				4. DATE OF DEATH (Month) (Day) (Year) 3 7 19 55			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH July 20, 1877	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Woodwork		10b. KIND OF BUSINESS OR INDUSTRY Cabinet maker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Stokes				14. MOTHER'S MAIDEN NAME Mary Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Richard Stokes #2	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				3 day			
IMMEDIATE CAUSE (A) Cerebral Vascular Accident				yes			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Cerebro							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Benign prostatic hypertrophy				yes			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/31/55, to 3/17/55, that I last saw the deceased alive on 3/16/55, and that death occurred at 11:55 PM, from the causes and on the date stated above.							
SIGNATURE Richard M. Stokes				DATE SIGNED 3/18/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 3/10/55		NAME OF CEMETERY OR CREMATORY Cedar Bluff		LOCATION (City, town, or county) (State) Annapolis, Md.	
24. REC'D BY REGISTRAR DATE March 9, 1955		REGISTRAR'S SIGNATURE J. M. Taylor		25. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor and Sons Annapolis, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS A15C 1-55 10M

UNITED STATES

JAN 11 1901

2301

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN PasadenaHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

-- Route 1, Box 372

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

A.A.

CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN PasadenaSTREET
ADDRESS

(If rural give location)

Route 1, Box 372

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

JAMES

P.

STRONG, Sr.

4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

Mar.

1

19 55

5. SEX:

male

6. COLOR OR
RACE:

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): married

8. DATE OF BIRTH:

Sept. 24, 1885

9. AGE last birthday:

69 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min.10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if retired):

Brakeman (rtd) Railroad

10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Md.

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

Earl R. Strong

14. MOTHER'S MAIDEN NAME:

Anne Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

9

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mrs. Carrie C. Strong - Pasadena, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent causes(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between
Onset And Death

8 hours

5 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

Generalized arthritis

3 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY m.INJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 5, 1954, to March 1, 1955, that I last saw the deceased

alive on Feb. 28, 1955, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3-2-55

R. M. McLaughlin, M.D.

Pasadena, Md. March 1, 1955

Balto., Md.

Diner

Balto 17, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2392

02286

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Crownsville</u>		<u>34 yrs. 4 mos. 9 days</u>		<input checked="" type="checkbox"/> TOWN <u>Baltimore City</u>		<u>3-1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Mamie</u> (Middle) <u>Taylor</u> (Last) <u>Taylor</u>				3 5 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Negro</u>	<u>Married</u>	<u>1887?</u>	<u>67?</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME <u>Jerry Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				Progressively present since adm. 10/27/20			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/21</u> , 19 <u>48</u> , to <u>3/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/5</u> , 19 <u>55</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>3/5/55</u>			
M.D. <u>Crownsville, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>3/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Crownsville State Hospital</u>		LOCATION (City, town, or county) (State) <u>Crownsville Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Crownsville, Md.</u>	
DATE <u>3-17-55</u>							

BUREAU V. S.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

23'3

CERTIFICATE OF DEATH

02287

28

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>16 yrs. 9 mos.</u>		CITY (If outside corporate limits, write RURAL end give nearest town) TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1507 N. Calhoun Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Rufus</u> (First) <u>Taylor</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>1892?</u>	9. AGE last birthday <u>62?</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Delia Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>				INTERVAL BETWEEN ONSET AND DEATH			
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Cardio-vascular Disease</u>				Known to us since <u>12/25/54</u>			
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/21</u>, 19 <u>48</u>, to <u>3/2</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>3/2</u>, 19 <u>55</u>, and that death occurred at <u>4:15 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removed</u>		DATE THEREOF <u>3/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>University Hospital</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>3-7-55</u>							

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02288

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

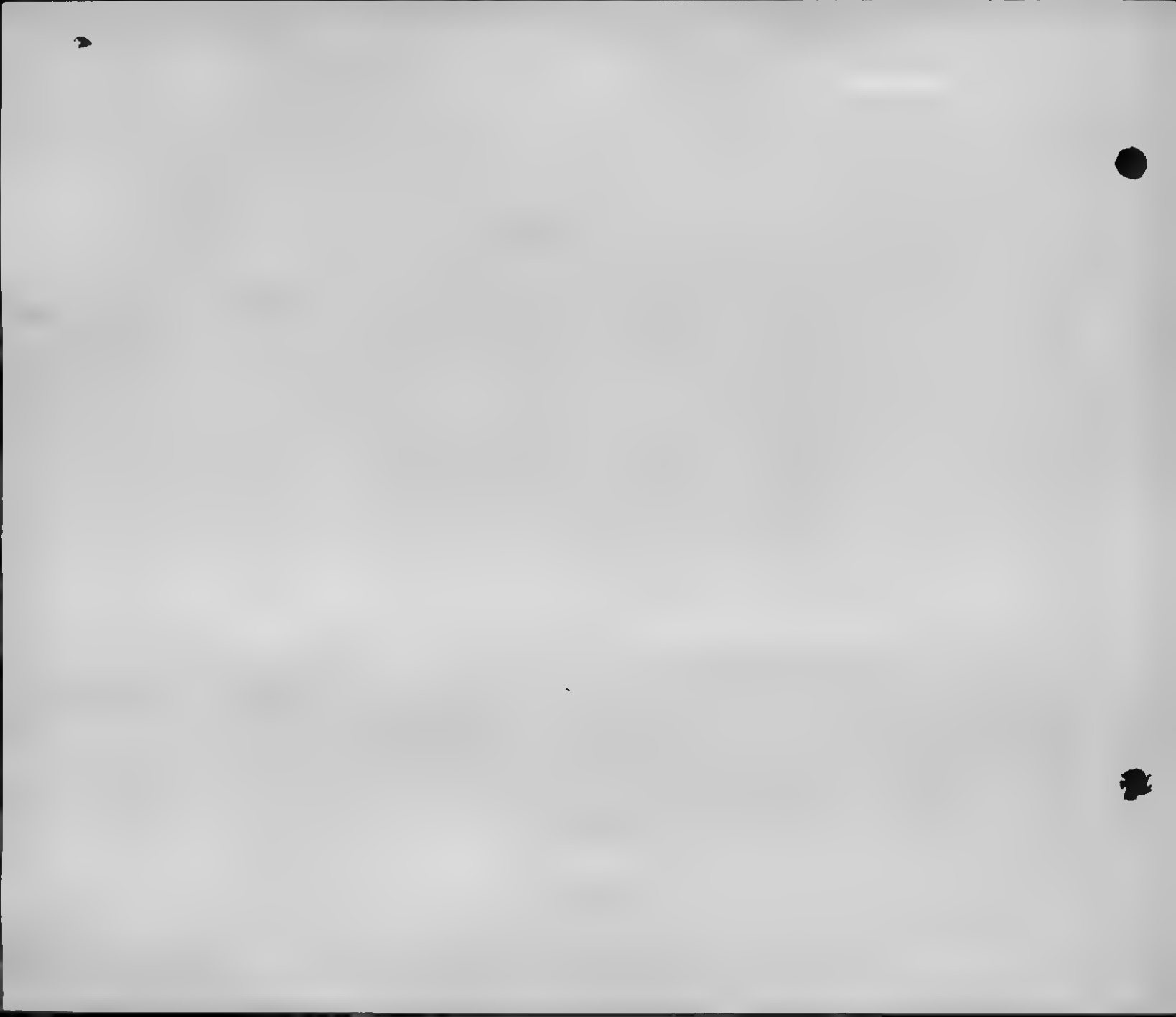
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR	TOWN
TOWN <u>Annapolis, Md</u>		TOWN <u>Wardour Annapolis Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>		STREET ADDRESS (If rural, give location)	
		<u>208 Norwood Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Josephine Stafford Thomas</u>		<u>MAR. 12 1955</u>	
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>female</u>	<u>white</u>	<u>widow</u>	<u>Sept 18 60</u>
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	9b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: yrs.	10. CITIZEN OF WHAT COUNTRY?
<u>housewife</u>		<u>74</u>	<u>USA</u>
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Urbania Ohio</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
<u>no</u>		<u>None</u>	
17. INFORMANT & ADDRESS:			
<u>Mrs Martha C. Stent, 208 Norwood Rd</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Pneumonia</u>			<u>Feb 8 55</u> <u>1 mo plus</u>
DUE TO			
(b) <u>Fracture left hip</u>			
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause			
stating underlying cause last			
(c) <u>Fall in her home</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Senility</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
<u>Feb 8, 1955</u>		<u>Comminuted intertrochanteric fracture left hip</u>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.)	21c. (City or town) (County)	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
	<u>Home</u>	<u>above address</u>	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb 8 55 12 A.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Slipped going to bath</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		DATE SIGNED	
<u>W. A. R. F. Stent</u>		<u>M. D.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3/15/55</u>	<u>St. Johns Cem</u>	<u>Ellicott City, Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>3/17/55</u>	<u>W. A. R. F. Stent</u>	<u>Barton Sons Latonsville Md</u>	

MARGIN RESERVED FOR BILLING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02289
2324 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundal</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<input checked="" type="checkbox"/> TOWN <u>Pasadena</u>				<u>Pasadena</u>		<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 Doris Ave.</u>				STREET ADDRESS (If rural give location) <u>1 Doris Ave.</u>			
3. NAME OF DECEASED: (First) <u>William</u>		(Middle) <u>Thomson</u>		(Last) <u>Thomson</u>		4. DATE OF DEATH: (Month) <u>March</u> (Day) <u>12</u> (Year) <u>19 55</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>8/23/1903</u>	
9. AGE last birthday: <u>51</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Salesman</u>		11. BIRTHPLACE (State or foreign country): <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Walter Thomson</u>				14. MOTHER'S MAIDEN NAME: <u>M.C. McCracken</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>716-07-5865</u>		17. INFORMANT & ADDRESS: <u>Mary T. Thomson 1 Doris Ave. Pasadena Md.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of stomach</u>		<u>6 months</u>
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Oct. 2, 1954, to Mar. 12, 1955, that I last saw the deceased alive on Mar. 12, 1955, and that death occurred at 8:25 a.m., from the causes and on the date stated above.

SIGNATURE R. M. McLaughlin (Degree or title) M.D. ADDRESS Pasadena, Md. DATE SIGNED Mar. 12, 1955

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE RECD BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>John A. Moran</u>		ADDRESS <u>3000 E. Falto. St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2395

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02290

Reg. Dist. No. 22

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel R.F.D.</u> OR TOWN <u>5 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> OR TOWN <u>MD</u> 1 41-1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Main st</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>HARRY CLEVERLAND WHITEHEAD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 20 1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Sept 17, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SKILLED LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber mill</u>	9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Whitehead</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Mason</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-14-16-17</u>	
17. INFORMANT AND ADDRESS <u>Florence Mason Laurel Rd</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Cornary occlusion</u>		4 hrs	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertension, acute Bronchitis</u>		1 yr +	
(c) <u>Hypertension stress disease</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Not White WORK <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/17</u> , 19 <u>55</u> , to <u>3/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Mar 20</u> , 19 <u>55</u> , and that death occurred at <u>8:30</u> m., from the causes and on the date stated above.			
SIGNATURE <u>D. B. Brinton</u>		ADDRESS <u>314 Confe-an Laurel Rd</u>	
DATE SIGNED <u>Mar 22 1955</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>buried</u>		DATE THEREOF <u>Mar 23, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Mary Hill</u>		LOCATION (City, town, or county) (State) <u>Laurel MD</u>	
DATE REC'D BY LOCAL REG. <u>Mar 22 1955</u>		24. FUNERAL DIRECTOR <u>Edward R. Ruff</u> ADDRESS <u>Ridgely Rd 401 Wash Ave Laurel MD</u>	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the funeral director, the third copy of this certificate has been excused by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2306

CERTIFICATE OF DEATH

02291
24

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Anne ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> LENGTH OF STAY (in this place) <u>2 months</u> OR TOWN <u>Baltimore</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR COVVALESCENT HOME, Route 2 Box 376A</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>...</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> OR TOWN <u>Baltimore</u> STREET ADDRESS <u>1303 Bloomingdale Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>BESSIE</u> (Middle) <u>WILLIAMS</u> (Last) <u>WILLIAMS</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>8</u> (Year) <u>1955</u>			
5 SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 14, 1892</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>...</u> Days <u>...</u>		IF UNDER 24 HRS. Hours <u>...</u> Min <u>...</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
13. FATHER'S NAME <u>William Bundy</u>				14. MOTHER'S MAIDEN NAME <u>Emma Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>...</u>		17. INFORMANT & ADDRESS <u>Albert Bundy</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
210x IMMEDIATE CAUSE (A) <u>Septicemia, Kachexia.</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes mellitus and</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>multiple abscesses of</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>skin & gangrene</u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21e. INJURY OCCURRED			
				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/15</u> , 19 <u>55</u> , to <u>3/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/5</u> , 19 <u>55</u> , and that death occurred at <u>10 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Joseph Taylor</u> M.D.				ADDRESS (Street, city, town, state) <u>103 Baltimore - Annapolis Blvd. Glen Burnie Md.</u>		DATE SIGNED <u>3/8/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 11/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Calvary Cem</u>		LOCATION (City, town, or county) (State) <u>A. A. County Md</u>	
24. REC'D BY REGISTRAR <u>C. W. Hedrick</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Robert A. Elliott & Daughter</u>		ADDRESS <u>11299 Carolina St</u>	
DATE <u>3/11/55</u>							

20-28-15

5-1-15

111

9

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

FUNERAL DIRECTOR The law requires that the death certificate be filed with the registrar within 11 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2259

CERTIFICATE OF DEATH

02292

21

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Riva</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>Sylvan Shores</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELAINE</u> (Middle) <u>WALLIS</u> (Last) <u>WILSON</u>				(Month) <u>MARCH</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>December 17, 1936</u>	<u>18</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Dentist attendant</u>		<u>Dentist's office</u>		<u>Worcester, Massachusetts</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Dr. John N. Wilson</u>				<u>Wilma V. Vierbucken</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>212-34-1823</u>		<u>Mrs Wilma Wilson- Mother- same as # 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
541.0 IMMEDIATE CAUSE (A) <u>Acquired Hemolytic Anemia</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Perforated Peptic Ulcer</u>						<u>3 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-7</u> , 19 <u>55</u> , to <u>3-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-11-55</u> , 19 <u>55</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Edward A. Beck</u>		<u>M.D. 411 Southgate Ave Annapolis</u>		<u>3/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>3-14-55</u>		<u>New Cathedral Cemetery</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>March 14, 1955</u>		<u>J. O. Daniel</u>		<u>B.L. Hopping and Son</u>		<u>Annapolis, Md.</u>	

BUREAU V. S.

MAR 15 1955

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02293

2307

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Crownsville</u>		<u>55 days</u>		OR TOWN <u>Cockeysville</u>		<u>03X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Almshouse</u>			
3. NAME OF DECEASED (Type or Print) <u>James Henry Winder</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 26 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>		8. DATE OF BIRTH <u>Unk.</u>	
9. AGE last birthday <u>70?</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Winder</u>				14. MOTHER'S MAIDEN NAME <u>Frances</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 days	
025X IMMEDIATE CAUSE (A) <u>Lobar Pneumonia</u>						known to us since 2/1/55	
ANTECEDENT CAUSE(S) DUE TO (B) <u>C.N.S. Syphilis, Meningoencephalitis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 1955, to <u>3/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/26</u> , 1955, and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/26/55</u>			
23. BURIAL, CREMATION, OR OTHER (Specify) <u>Burial</u>		DATE THEREOF <u>3/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Andrew's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>March 28, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

MAR - 195

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2398

02294

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Millersville, Md.</u>		<u>8 months</u>		TOWN <u>Baltimore</u>		<u>31 3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SANN'S Nursing Home</u>				STREET ADDRESS (If rural give location) <u>348 Ballou Court</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bertha</u> (Middle) <u>WOLF</u> (Last)				(Month) <u>MARCH</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. MARRIAGE STATUS (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>WIDOWED</u>	<u>Feb 5, 1877</u>	<u>78</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>OWN Home</u>		<u>Baltimore, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Brandt</u>				<u>(UNK)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>				<u>HARRY C. WOLF, SR. Glen Burnie, Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
<u>443X</u>						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)						<u>Hypertensional Cardio-Vascular disease + 8 months</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 8, 1955, to March 7, 1955, that I last saw the deceased alive on March 4, 1955, and that death occurred at 9 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Rebecca H. Buckner, M.D.</u>				<u>Glen Burnie, Md.</u>		<u>3/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>3/10/55</u>		<u>Glen Haven</u>		<u>Glen Burnie Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>3-10-55</u>		<u>K M Joyce</u>		<u>Hopping & Kirkley, Glen Burnie, Md</u>			

BUREAU V. S.

MAR 14 1965

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2309

CERTIFICATE OF DEATH

02295

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SEVERN (RURAL)</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SEVERN (RURAL)</u>		TOWN <u>SEVERN (RURAL)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS <u>Quarterfield Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Herbert</u> <u>Wolf</u>				4. DATE OF DEATH (Month) <u>MAR</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>OCT. 13, 1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AUGUST WOLF</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Nickolson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-03-6993</u>		17. INFORMANT & ADDRESS <u>Roy Wolf, Severn, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic Mitral Insufficiency</u>						<u>+ 3 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Interstitial Nephritis</u>						<u>+ 3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January</u> , 1951, to <u>March 11</u> , 1955, that I last saw the deceased alive on <u>March 10</u> , 1955, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Paulsen MD</u>				ADDRESS (Street, city, town, state) <u>M.D. Helen Busch, Md.</u>		DATE SIGNED <u>3/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>A.A. Co.</u>	
24. REC'D BY REGISTRAR <u>4/16-55</u>		REGISTRAR'S SIGNATURE <u>Helena Hoadley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley</u>		ADDRESS <u>Glen Burnie Md.</u>	

100-20000

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

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CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

APR 4 1955

RECEIVED

ENCLOSURE